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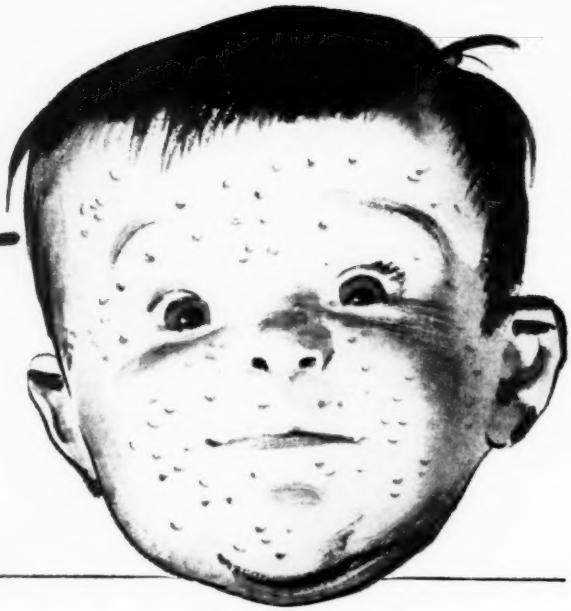

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PUBLIC HEALTH NURSING

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STAFF EDUCATION AND QUALITY

The guiding principles of staff education have been admirably stated by Dorothy Wilson in her doctoral project on this subject. We are happy to publish one of her chapters in this issue. Miss Wilson bases her principles of staff education on three factors—factors that are fundamental and vital. First, staff education is one means by which the nursing agency seeks to attain its ends. Second, staff education is planned for adult workers who although they may vary in their professional development, participate in a joint undertaking. And finally, staff education is but one aspect of all education—education for living and working.

Public health nursing agencies have always assumed the responsibility for conducting some type of in-service education activities. Today staff education is a live issue.

In the immediate postwar years, colleges and universities including those offering approved programs of study in public health nursing had heavy registrations. The public health nursing field absorbed all those who completed their preparation and still there remained many hundreds of vacancies. Today enrollment in universities is beginning to decrease; this is true for the number of students seeking preparation in public health nursing as well as in other fields. It means we continue to be faced with a larger number of unfilled positions and a smaller number of qualified applicants.

In the past when administrators employed graduate nurses without public health nursing preparation they depended upon an orientation and in-service education program to safeguard the quality of service. Today when society expects a greater contribution from nursing than before, even more careful plans must be evolved if we are to have not only adequate quantity but also high quality in public health nursing.

Although the pattern of nursing education is definitely changing, many of today's graduates did not have the benefit of the enriched curriculum offered in the modernly conceived collegiate professional basic school of nursing. It is to the expansion and strengthening of such schools that Esther Lucile Brown recommends the profession direct its efforts. Graduates of such schools, it is hoped, will be ready for beginning positions under supervision in any field of nursing, in institutions or agencies. This is true at present of the graduates of the five schools approved jointly by the NOPHN and NLNE (page 173). Public health nursing service will reap the benefit of further development of this type of basic nursing education.

In the past and for some time to come, the 33 colleges and universities with programs of study in public health nursing, approved by the NOPHN, have provided and will continue to provide supplemental education for those graduates whose basic nursing study did not include preparation for public health nursing.

Many graduate nurses are prohibited by economic reasons from seeking supplemental study. It is hoped some will be helped by the more effective use and distribution of now available scholarship funds and that additional

aid will be forthcoming through federal legislation. But even for those with the requisite background there is the continuing need to keep abreast with modern medical and social sciences and practice.

There will always be a need for some kind of continuing staff education program in all types of public health nursing agencies. This is the main topic of the current issue of the magazine. It is the responsibility of all administrators to provide for expanded and carefully designed and executed staff education programs. This responsibility is inherent in the larger responsibility to provide the highest quality of service to the people. It can be generally assumed that a positive correlation exists between a dynamic staff education program and the improvement of quality of nursing service an agency renders a community.

Several articles this month discuss the philosophy and methods of staff education. Although a staff education program should not be concerned primarily with making up the deficiencies in a nurse's basic preparation, if one is to be realistic today when two thirds of nurses in public health positions have not completed even one year of public health nursing study, it is necessary that at least the elements of public health nursing principles and practices, as well as content in some clinical areas, be incorporated in in-service training programs. As Theodora Floyd says, page 139, pressures to employ *any* nurse rather than have *no* nurse are difficult to withstand and she tells what can be accomplished by organized planning in on-the-job training. We learn by doing. This is a point also ably made by Pearl Shalit, page 130. Edna Brandt, page 143, shows how it was found out, in connection with a city-county mass x-ray program, what were the nursing staff's gaps in knowledge of tuberculosis, and how special preparation in this clinical field was provided quickly and received enthusiastically.

There are methods of staff education that are familiar, tried and true. And there are new methods to be explored and perfected.

The NOPHN Education Committee at its meetings in November 1948 gave some thought to the question of staff education. The members of this committee believe that more effective plans can be formulated and carried out when responsibilities for such programs are mutually shared by educators and administrators concerned with the quality of the nurse's preparation. There was a belief that the university through its faculty and rich resources could offer material assistance and make a vital contribution in enhancing the quality of staff education programs. Experimentation is needed and is anticipated.

Writing in the early years of the century, Edward L. Thorndike said, "The arts and sciences serve human welfare by helping man to change the world, including man himself, for the better." We who are concerned with the betterment of the world about us must be ready to promote the growth of professional workers so that each day sees us better prepared to give that something to our communities which is uniquely the contribution of public health nursing.

YEAR-ROUND PROGRAM REPLACES "WEEK"

Several agencies have written recently to NOPHN Headquarters asking for material to help in the promotion of National Public Health Nursing Week—despite previous announcement that the NOPHN board voted at the Biennial Convention last May to discontinue observance of the week on a national scale. (See the September 1948 PUBLIC HEALTH NURSING, pages 478-9.)

This action was taken following reports from representatives of a large number of agencies who said they believed the week had served its purpose in arousing new interest in public health nursing in their communities

and that they believed this new interest could best be kept alive by day-by-day activities throughout the year, rather than by concentration on a single week.

Helen Nelson, new director of public information at NOPHN Headquarters, who came to work February 1, has begun, with the assistance of other staff members, particularly those from the promotion department, to bring up-to-date suitable material already on hand,—loan folders, exhibits, posters, pamphlets, and the like. She will prepare also new materials which will help local nursing agencies in their daily work toward obtaining increased community recognition and cooperation.

As this work gets under way the assistance will be sought of the Board and Committee Members Section, and of course, advice from our member agencies throughout the country as to their particular needs.

Announcements will be made in the magazine from time to time as to what new and revised materials are available.

In the meantime agencies who see a need for a Public Health Nursing Week in their community may, of course, promote a local week. The PHN Week kit for 1948 is now available from 1790 Broadway at the reduced price of 50 cents, and new material as it is prepared may be adapted for this special purpose.

THE YEARLY REVIEW

Soon 1,000 public health nursing agencies across the country will receive a questionnaire from NOPHN known as the "Yearly Review." Since 1924, through this medium, official and nonofficial agencies have generously given time and thought to answering questions about their services. The tabulation and interpretation of these data constitute much of our body of knowledge on public health nursing theory and practice in this country.

The first Yearly Review was on salaries. Subsequent questionnaires have covered almost every aspect of public health nursing one can think of. The study of tuberculosis services (page 154) is an example. The Review not only provides historically valuable data, but each year helps to solve currently urgent problems.

If the 1949 Yearly Review comes to *you* for reply, remember its all-time, nationwide significance. Thank you for helping!

MARCH IS AMERICAN RED CROSS MONTH

Community safeguards depend upon a united people. Especially in time of disaster efficient functioning is necessary if lives are to be saved and the injured and homeless given practical aid. That is why an organization such as the American National Red Cross is necessary. Haphazard planning won't do. People must know where to turn, how to coordinate their efforts to help.

The Red Cross was able to coordinate the services of civic groups last year when more than 300 disasters struck in widely separated communities. The growing Red Cross National Blood program is another illustration of the partnership that makes service possible.

All Red Cross work is divided between community volunteers and a full-time staff. Whether the work is educational and preventive, such as first aid, water safety, accident prevention, home nursing, nutrition; or remedial, such as aid to veterans, servicemen, and civilians, both hospitalized and able-bodied,—the Red Cross counts on community cooperation.

Let us continue to have faith in this people's partnership to the end that we will contribute our money, our time, and our moral support to make the 1949 Red Cross fund campaign a success. The month of solicitation is March. The service is year-round.

EXPERIENCE WITH NATURAL CHILDBIRTH

FREDERICK W. GOODRICH, JR., M.D.

A CURRENT MAGAZINE advertisement proclaims the provocative phrase "Never underestimate the power of a woman." Our experience in the Obstetrical Service at Yale University bears evidence of the essential truth of this statement. If any one individual or group of individuals can be said to be responsible for the initiation of our interest in natural childbirth, it is certainly those women who told us that they intended to have their babies according to the principles outlined by Dr. Grantly Dick Read—*and they did exactly that!*

We were fortunate that our first volunteer patients were so successful. Had they not been, there is every possibility that our interest would have flagged. A survey of these first twenty patients revealed several interesting facts and posed several questions. First, here was a method which allowed women to deliver their babies with little or no anesthesia and yet without undue pain or discomfort. Second, there seemed to be a definite emotional or psychic advantage. Here were women who seemed to enjoy experiencing childbirth while fully conscious. Third, all of our patients appeared to be of a particular type—wives of Yale students, better educated and more widely read than the usual clinic patient. They had all read Dick Read's *Childbirth Without Fear* (Harper, 1944) and were convinced that they wanted it when they had their babies.

Did natural childbirth require a degree of intelligence above the average, a good patient-physician relationship, and an overwhelming desire for it? If this were so, then the method would be applicable only to a small proportion of women.

We felt that the patients in a teaching obstetrical clinic should provide a good test, since the majority of patients come from the lower socio-economic groups, in general have a poor educational background, and no knowledge of or interest in natural childbirth.

A study project was outlined in which every third patient who registered in the prenatal clinic was selected for natural childbirth. These mothers were instructed according to Dick Read's methods in anatomy and physiology of pregnancy and labor. This instruction was kept on as simple a plane as possible and confined to two lectures of forty minutes each. Relaxation was taught individually as a part of each prenatal examination.

Soon we met up with our first patients who, although they had been taught to the best of our ability, needed enough medication to prevent them from being awake during the birth of their babies. These we classed as failures, although the reason was not obvious to us and little help could be had from Dick Read's writings. It will be recalled by those who have read *Childbirth Without Fear* that it deals mainly with general principles and contains little specific information about the exact management of patients.

Dr. Goodrich is Maternity Center Association Fellow in obstetrics and gynecology, Yale University School of Medicine.

The advent of Mrs. Helen Heardman, an English physiotherapist, sent to us by the Maternity Center Association helped us to solve this problem. She taught us the physiotherapeutic technics of relaxation—methods of teaching the prenatal patient and the use of technics during labor which enabled some of our patients, although unprepared, to have their babies without undue difficulty while awake. We immediately incorporated the exercises in our prenatal program by teaching the patients individually at the clinic and by giving them mimeographed reminder sheets.

Individual instruction, however, was impractical in a busy hospital. The solution to this dilemma appeared when the Maternity Center Association established two fellowships for specially prepared nurses who were assigned to the obstetrical service. With the assistance of these nursing fellows, four exercise classes were organized and integrated with the lectures.

By the spring of 1948 the patients were being given a total of six classes during the prenatal period. These consisted of one lecture and two exercise classes during the early prenatal period. Another lecture and two more exercise classes on labor and delivery were given in the last month of pregnancy. The last class concluded with a tour of the obstetrical division, labor, and delivery rooms.

After delivering 156 patients, we found that we were dealing with an entity, parts of which defy statistical analysis. It is as difficult to measure degrees of pain as it is to assess quantitatively the expression of joy on a woman's face when she first sees her newborn infant. The reaction of our patients, however, was not just favorable but so overwhelmingly enthusiastic that we felt the principles of natural childbirth should be more widely applied and studied. Approximately 80 percent of the patients had been delivered while conscious; 90 percent of these had actually enjoyed the experience or stated that it was not unpleasant. In all but a few cases, it was evident that the program had had some good effects. The result did not seem to be affected by any one single specific factor such as age, intellectual ability, emotional stability, length of labor, size of baby, parity, or attendance at classes.

There were, however, some mothers who had a considerable amount of pain which they endured, without anesthesia, to please the nurse or doctor. Afterward, they looked upon their labors as unpleasant in the extreme and did not enjoy contemplating future deliveries. These we classified among the failures.

Some of the mothers classified by us as failures, on the other hand, reported that they had derived great benefit from the training program and attention during labor, and would like to receive the same treatment in future deliveries to which they were looking forward.

From our experience with these first 156 patients, we were able to define our aims as (1) to enable every mother to have a safe labor and delivery and (2) to enable every mother to have an emotionally satisfying labor and delivery. Because we felt that our aims were being achieved with this selected group, there seemed to be no reason why the benefits should be confined to only one third of the patients. The program was therefore enlarged to include all clinic and staff patients.

Some reorganization was necessary to accommodate these added mothers. The actual number of classes remained the same for each mother, but the classes had to be given more frequently. In addition, it was necessary to familiarize the entire medical and nursing staffs, both student and graduate, with the technics to be applied to all patients. This was done in numerous conferences, classes, and seminars. The Maternity Center nursing fellows discontinued the practice of attending all patients in labor, and served in a supervisory role, instructing the other nurses in the art of caring for patients in labor.

In this expanded project, we now have data on 250 more patients who have delivered since August 1948. We know that we have achieved the desired end in almost 90 percent of these patients—87 percent have been fully conscious at delivery, 92 percent of all deliveries have been spontaneous, the operative incidence being about 8 percent.

Through carefully prepared questionnaires, the majority of mothers do not hesitate to express their opinions. Their remarks have been most helpful in guiding our curriculum in the classes and our approach to the patients in labor. We have learned much concerning the general emotional reactions and mental processes of parturient women.

The mothers are almost uniformly in agreement that they have derived great benefit from the lectures. Many have readily admitted that they had not realized how little they knew about having a baby.

IT IS OUR BELIEF that the most important aspect of the whole program is the support given the patient during labor. This is characterized by sympathetic understanding of the psychic and somatic needs of the individual patient and an attempt to satisfy these needs. This support best begins in the preparation of the patient for labor by teaching her what to expect physically, mentally, and emotionally. This instruction must be reinforced during labor. It is given by the nurse who is in constant attendance and by the doctor on frequent visits he makes to the patient.

The physical aspects of support consist of aiding the patient in relaxation technics, massaging the back during contractions, and doing all those simple but vital things which have been the province of the nurse since the time of Florence Nightingale.

Mental and emotional support is founded in the sympathetic, calm and confident approach of the doctor and nurse to the patient. The purposes and findings of the various examinations and procedures are frankly discussed with her. It is gratifying to note the effect on the patient when the position of the baby is explained to her and she is permitted to listen to the fetal heart.

As the labor progresses, the mother is kept informed of the degree of cervical dilatation. If she is told what to expect in advance of the actual occurrence, she is much more apt to maintain her control. During the second stage the patient is offered the opportunity to watch the delivery in a mirror; whether she avails herself of this opportunity or not, she is kept informed of the progress of events by a running verbal account given by the physician. She is always reminded that anesthesia is available for her immediate use at any time she wants it. Above all, she is constantly reassured as to the normality of the labor and her reaction to it. This is extremely important as most patients need to be told that they are doing well. The guiding principle in offering support is that every patient is an individual and should be treated as such.

The exact role of the doctor and nurse cannot be defined because they are mutually interdependent. It is essential that the doctor be present at the critical periods of the labor, when the patient is under the greatest stress even though at these times he can do no more than to reassure her. It is obvious that most busy doctors cannot attend the entire labor of every patient. A competent, understanding nurse is therefore invaluable in supporting the patient when the doctor cannot be present. Such a nurse can derive great satisfaction from the realization that her abilities are essential in furthering relaxation. This type of service is much more rewarding in personal satisfaction than the usual routine duties of an obstetrical nurse who often does no more than administer scheduled drugs and see that the patient does herself no harm. As one of our patients put it, "The nurse serves as a kind of link between the doctor and the patient and the services of each are essential."

IF THERE IS a common factor which determines success or failure, that factor is anxiety. There is a large amount of anxiety centered on childbirth in every woman. Since this anxiety is mainly unconscious, the patients themselves are often not aware of it. This unconscious anxiety is often not within reach of our indoctrination program. Patients with a great deal of unconscious anxiety which does not respond to treatment are often best delivered while asleep. However, in all women the effort to allay anxiety is well worth while. There is nothing to lose and everything to gain by preparing all women for

childbirth and supporting them while they are having their babies.

One important way to help in allaying anxiety is to encourage the husbands' presence in the labor room. They, with a little instruction, become back rubbers of surpassing excellence. Numbers of women have expressed their gratitude for the simple fact that their husbands were there. After all it is hard to deny that the husband has a vital interest in the birth of his baby and his relegation to an impersonal waiting room is a complete denial of this interest.

The impact of natural childbirth is manifest not only in the mothers but also in the medical and nursing staffs who have found that there is a great deal of personal satisfaction to lending support to mothers in labor. The students, both medical and nursing, become uniformly enthusiastic and it is a source of great satisfaction to us to realize that the students now in training at Yale are leaving New Haven imbued with a knowledge of the value of humane obstetrics.

THERE ARE several misconceptions about natural childbirth which need to be corrected. One common belief is that it is painless childbirth. Only about 2 percent of our patients have found that it is completely painless and these were completely relaxed and apparently without anxiety. The majority of our patients state that they do feel some pain, which they are quite willing to tolerate in view of the exaltation accompanying conscious delivery.

Another misconception is the belief that natural childbirth prohibits the use of any drugs. Only 35 percent of our 400 patients were delivered with no analgesia or anesthesia whatsoever. Approximately 52 percent of the remainder had small doses of demerol, or nitrous oxide inhalations with contractions, or both. Only 12 percent had enough analgesia or anesthesia to be completely unconscious. The mothers are instructed to ask for drugs if they feel the need of them and we have found that little more than half do need minimal amounts.

The third belief is that the exercises in themselves will enable women to have natural childbirth. Many women write requesting the exercises for "painless childbirth" and few seem to realize that proficiency in doing the exercises alone is not enough. There is the very real danger that women who do not receive support will find the exercises of little help alone and consequently will condemn the entire method.

Our experience has led us to the following conclusions. Natural childbirth is feasible in a teaching ward service. It is now well past the initial study phase and its general applicability as well as its desirability have been amply demonstrated. The enthusiasm of our patients and the widespread interest of women everywhere seem to indicate the need for its adoption by other teaching centers in order that doctors in active practice as well as future doctors and nurses may become familiar with its use. When this occurs, there is little doubt that many of the answers to questions still unanswered will be rapidly forthcoming and the opportunity to have babies happily as well as safely will be vouchsafed to all mothers.

DURING these past 15 years every effort has been pursued to drive death from the delivery room by the most efficient technics. The toll *was* taken from maternity but in its place has grown a mechanistic monstrosity. A mother rushes to the hospital, goes to sleep and produces a baby which she is shown many hours later but is unable to hold or cuddle except under the strictest surveillance. Father doesn't count. He simply pays the bills and gets a fleeting glimpse of his new baby through a solid glass.

It might be helpful to state what the Maternity Center Association believes is the essence of natural childbirth. It is the birth of a baby by natural physiologic processes in which the mother consciously participates from beginning to end, with neither instrumental nor operative aid or interference, and without injury to mother or baby.

MRS. SHEPARD KRECH

From remarks at the annual meeting of the Maternity Center Association, New York, January 20, 1949

STAFF EDUCATION: PRINCIPLES AND PURPOSES

DOROTHY WILSON, R.N.

STAFF EDUCATION in public health nursing is one means of providing good service in a community. The unique purposes are:

To assist nurses to adapt their present abilities and to acquire new ones as required by their work

To promote professional development of staff which yields work satisfaction and increased identification with the agency program

To provide the agency with a nucleus of staff whose mastery and interest in their work contribute to an increasingly high quality of service

To assure agency of staff prepared to assume different or added responsibilities when the need appears.

The following principles of staff education in public health nursing have been derived from a consideration of the role of staff education in a service agency, the persons participating in it, and its place in all education.

Programs for staff education in public health nursing should have:

1. Aims based on cooperative study of present and anticipated agency functions and the assistance nurses will require to implement them.

2. General direction, assigned as an integral part of the agency administration, by one person recognized by the staff as professionally competent and mature.

3. Longterm plans assuring continuity and flexibility by providing for persistent and recurring needs of the staff, and allowing for needs created by changing conditions.

4. Placement of educational activities which tend to integrate them with other activities essential to the agency's program.

5. Selection of specific activities which recognizes and uses the contributions made to professional and personal growth of the staff by other educational resources available in the community.

6. Balance among activities provided for the total staff, for parts of the staff, and for individual members, which reflects the proportionate value of such activities to the agency program.

7. Leadership that promotes participation in planning and operating activities by all members, in keeping with each individual's present ability and interest.

8. Leadership in particular activities determined by an individual's ability to provide new information, help clarify ideas, and stimulate new learning.

9. Definite allotments of agency resources, material and human, and responsible accounting for their use.

10. Provision for periodic review, evaluation, and revision of the program.

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THE FIRST FACTOR accepted as a basis for formulation of the principles as to the desirable characteristics of staff education has been stated as *staff education is one means by which the nursing agency seeks to attain its end.* Staff education then is a means through which a larger enterprise seeks to meet its purposes.

Direction of staff education should be recognized as an integral part of the administration of the agency. As one process which contributes to the attainment of a common purpose, staff education must be planned and directed so that its activities add to and do not interfere with the effectiveness of other essential activities of the agency. In a small service leadership may be assigned as one of several administrative functions. In a large one it may be the sole responsibility assigned to an administrative officer. But in any situation one person should be responsible for the development and oversight of all educational activities so that these activities themselves have consistency and unity and in order to relate them effectively to other agency functions.

The aims of staff education should be pertinent to those of the agency and the activities of the educational program should demonstrably contribute to the attainment of agency goals.

Access to agency resources that enable it to operate effectively should be accorded staff education as one accepted process of administration. Its allotment should be planned or budgeted so that the program is assured of necessary support and also keeps within limits determined as its reasonable share. Resources include both the funds available for securing material and speakers and the time of personnel that may be devoted to activities of the educational program. The person responsible for the program should be accountable for the use made of these resources. Accounting should also recognize the importance of selecting activities to be sponsored by the service with consideration for educational opportunities available outside the organization. Whenever possible the staff should be encouraged to use university courses which will extend and deepen professional knowledge.

Since staff education is justifiable as it contributes to the improvement of service it must recognize and provide the assistance each nurse needs to improve her performance. Improvement and maintenance of excellent nursing service depends on the extent to which each nurse develops her professional competence.

THE SECOND FACTOR accepted as a basis for developing the principles has been stated as *Adult professional workers engaged in a common enterprise who vary in professional and personal maturity and in capacity for development are the participants in staff education programs for public health nurses.*

Public health nurses give active and often enthusiastic support to educational experiences which they recognize as pertinent to their interests and daily work. This is even more marked when activities are designed to foster the nurses' initiative and participation and to allow some freedom in the choice of activities and the character of participation. As adults most members of the nursing staff have developed a noticeable degree of independence in thought and action.

Longterm plans for the staff education program make it possible for each individual nurse to make her choice of activities intelligently. The plan should permit nurses to learn what opportunities in the total staff education program will be available to them later. Thus the individual nurse can arrange the sequence of activities in which she participates to promote her professional progress.

Leadership from a professionally mature and competent person is not only accepted but is sought by adult professional workers. They participate willingly in activities such a leader takes responsibility for instigating, developing, and managing. Nurses realize that broader knowledge and wider professional experience may have enabled the leader clearly to recognize and define needs about which they are vague, and to analyze factors as a basis for planning to meet the needs. The development of an introductory program for new

staff is based on this acceptance by a group that the person or persons who have knowledge of the conditions of their new assignment will be competent to judge what information and experience they need to assume their responsibilities.

Staff education should provide some common educational activities for all members of the group. The content and level of instruction should be built on the base line of professional preparation which prevails among the staff. Although there are variations in the quality of basic and advanced nursing education in different institutions all nurses on a particular staff will have secured a determinable minimum of professional preparation. By accepting employment in a particular agency each member of the staff tacitly accepts the aims of the service program. Many problems the individual meets are similar to those of her coworkers and her needs for educational experiences are frequently like those of other members of the staff.

Staff education programs must be flexible enough to allow for the exercise of individual interests. One nurse may have had an unusual experience that has directed her interest toward a particular aspect of the agency service so that she has a desire to study and explore it exhaustively. Another may find that the conditions under which she secured part of her basic preparation leave her unsure in meeting the demands of some aspect of service. Both these nurses would be better practitioners if their interests were followed and some provision was made for them to secure the help they want. Longterm plans make it possible to anticipate the periodicity of recurrent educational needs. For example, nurses newly assigned to an agency may not benefit greatly from a unit planned for nurses who have been employed for a year or more and are extending their responsibilities.

The program should be designed to balance activities for the entire staff, for small groups, and for individuals in terms of their importance to the goals common to all the staff. Nurses sharing in a common enterprise learn to conform to controls established to help the group work together effectively and smoothly. As professional workers they expect to assume personal responsibility for securing some professional education in their free time. This is frequently demonstrated by their willingness to prepare for group study in off-duty hours.

Accounting for time devoted to staff education tends to safeguard time which should be available for other professional and personal activities. As adults nurses have vital interests outside their profession which will engage a large part of their nonworking hours. Preparation for agency educational activities made in off-duty hours should not be permitted to encroach on these interests. This can be avoided by planning to reduce educational activities during periods when work pressures are likely to be heavy, and by spreading all activities to eliminate periods of intensive study which could not be encompassed in working time.

THE THIRD CONTRIBUTING factor has been stated as *staff education is a part of all education for the persons concerned.*

Staff education must take responsibility for determining how the program is to be related effectively to education provided by other institutions in the community. As part of professional education it will be especially concerned to relate its contribution with other professional activities.

Staff education shares in the total professional and personal growth of staff members and has responsibility for using, to group advantage, the unique contribution each brings from outside educational activities. The unity of all education implies that all group and individual experiences, whether professionally oriented or not, have an effect on future experiences. Thus a nurse who studies the literature of some ethnic group will not be pursuing essentially professional study but may secure increased understanding of representatives of the group with whom she works and so brings new values to a staff study of methods for interpreting health needs to the ethnic group.

Many work activities of the staff have educative values which would be enhanced

and illuminated by activities designed primarily for educational purposes. For example, when a staff are redistricting the area in which they work, part of the time devoted to their consultation together may be used for a review of studies and reports which would guide them in selecting factors to be considered.

Leadership in educational activities should be vested in the person best able to assume it under the given conditions. Dewey says: "The mature person, to put it in moral terms, has no right to withhold from the young on given occasions whatever capacity for sympathetic understanding his experience has given him." Although general leadership should be provided through one person's leadership in specific activities it may well be passed from individual to individual among the staff.

CONCLUSION:

The statements of purposes and principles reflect the point of view on which is to be built the guide for staff education in a particular agency. They reflect concern for individuals and their prerogatives but also concern is included for their responsibilities as members of a group whose goals of service they accept as their own.

THE ART OF CRITICISM

Boys flying kites haul in their strings like white-winged birds,
But you can't do that way when you're flying words;
Careful with fire is good advice we know;
Careful with words is ten times doubly so.
—WILL CARLETON

Of all the commodities of this world there is none so dear, and none so cheap as Criticism, nothing so easy to give, so hard to take nor so impossible to take back.

The Art of Criticism is in the giving, the merit wholly in the taking. Lightly given it is lightly taken, given unkindly it is taken unkindly; given with sympathy and understanding it may plant good seed and bear good fruit. The chief requisite of this understanding is to understand not only the grounds of the criticism but the mind and heart of the one to whom it is directed. For honest criticism can only thrive in honest soil. . . .

The first thought of the critic must be to the purpose of his criticism. If it has no purpose it may better be withheld. Finding fault is not criticism. Fault finders are unhappy people who usually bestow the excess of their unhappiness upon others. If fault is all you can find, better keep your findings to yourself. Thus it is always better to offer criticism not as the correction of a fault but rather as an improvement of something that is already well done. . . It is better to present any criticism in the guise of something that the other had doubtless thought of but had not taken time to put into words or action.

Criticism that hurts seldom helps. Fearless criticism, however applauded, is still foolish. It is the part of wisdom to fear the consequences of untoward or untimely criticism. Avoid arrogance or pedantry as you would the plague. You will not detract from your stature by saying, "I may be wrong." You will add to it by saying, "I was mistaken."

Substantiate your criticism with facts and with reason, remembering that reason is always more persuasive than fact. Define the benefits to be derived from the course of action you recommend or the repair of the fault you criticize.

Beware of excitement which is the betrayal of weakness. The table pounding critic seldom makes more of a dent on his listener than he does on the table.

Say it with a smile. You can take the curse off the sharpest criticism by the way you tender it. A twinkle in the eye, a touch of humor in the voice, or in the words you write, are much more effectual, and longer remembered, than a kick in the pants.

Then this is the crowning precept—Always put yourself in the other fellow's place.

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SUPERVISOR AS COUNSELOR

Through guidance of individuals the supervisor helps to develop increasing nurse expertness

PEARL R. SHALIT

LEARNING, like living, is a dynamic process. No one can do another's living for him—no more can he do his learning. In the words of a great educator, "Tell a man how to do a thing, and he will not know how to do it; show him by doing it before his eyes, and he still will not know how to do it. The only way for him really to learn is by doing it himself." The first principle in guidance therefore, is that it must be a shared experience in which both the nurse and counselor take part.

Guidance, like other helping processes which involve contact between two or more individuals means the consideration of interpersonal relationships. Every contact between human beings is affected by "feeling tones" which are reflected consciously or otherwise in our attitudes, and determines our behavior in given situations.

This principle becomes especially important when we realize that guidance, to be effective, should be a continuous process of evaluation of the measure of success which the nurse has already attained and the groundwork for laying plans for her future growth.

The choice of counselor (term used in a functional sense, not designating a clinically trained individual) becomes significant in setting the pattern for the guidance relationship since the motivating forces which determine the rate of progress in any individual are primarily emotional in character. Growth proceeds most normally in an understanding and permissive atmosphere, an atmosphere that also has well defined limits. Unlimited freedom, overprotection, or piled up frustrations create additional hurdles or may block progress altogether.

In some organizations it may be necessary for several people to share in the guidance program. It is important, however, that some personnel, preferably those divorced from administrative functions, be assigned counseling as a full-time responsibility. To help the individual worker relate herself to the function of the total agency requires special skills and availability. An understanding of the dynamics of human behavior, the ability to create an environmental atmosphere which attempts to meet the needs of the individual and at the same time hold her to the minimum standards of performance for the total group, and the ability to be a good listener (not necessarily non-directive) are fundamental skills needed by a good counselor.

The nurse, too, comes into the picture with certain well developed characteristics. The nurse comes to the agency with professional knowledge and skills and with personal experiences, interests, and attitudes. We may set clock hours for the implementation of the former but the latter have no such time limits. Personal experiences and attitudes are an integral part of the nurse's total personality and are reflected in her behavior for as many

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of the 24 hours a day that she is awake and conscious. And there are many who believe that these same factors continue to operate during the period of sleep and unconsciousness.

In order to make the best use of the nurse's capacities, it is important for the agency to consider both skill and motivation. The nurse's relations to members of the agency staff (in the largest sense—administrative, supervisory and staff—both professional, clerical, and maintenance) are a reflection of her relationship with members of her own family. The attitudes developed in childhood will in turn be reflected in her relationships with the individual patients and groups with whom she works. The nurse's ability to face facts, to think through and carry through a project, to undertake responsibility, to be confident and self-reliant and adaptable to changing conditions—these habits of behavior are patterns which she learned long before she came into nursing. The encouragement of the socially useful patterns the nurse already has acquired and the attenuation of those which tend to distort her personality growth can be influenced by the direction of the guidance she receives at the hands of the agency counselor.

WE HAVE LEARNED that the initial introduction of a worker to a job is one of the most strategic areas in guidance. We also know that one of the problems nurses want help with is how to make the initial approach to individuals and families and how to conduct interviews under a variety of circumstances. This fact provides a clue to the counselor for she can use her first conference with the nurse as an example of approach, of listening to an individual's problem, of outlining policy and function, of assisting the individual come to some decision, and helping him make a plan for the next steps.

A new worker comes to an agency knowing that she will be expected to supply certain information about her training and experience but she may not be as ready to discuss her reasons for applying for this particular job nor may she be anxious to discuss the reasons she left the last job. The nurse will want to know the extent as well as the limitations of agency functions. She will want to know what guidance will be available to her and what opportunity and responsibility she will have in policy making and program direction. She will be interested in plans for evaluation of her own and the agency's service and in resources within and without the agency for continued intellectual stimulation and the satisfaction of her emotional needs.

It is pretty certain that neither the agency nor the nurse is going to be able to secure the answers to all the questions which may arise during the initial conference or during the orientation period. In fact to attempt to do so might have the effect of creating confusion instead of clarification. A brief outline of agency objectives and an honest admission of the major hurdles which may get in the way of progress are the first steps. A tentative job description may be helpful. Joint evaluation of the nurse's experience to date follows naturally and should lead to planning of the work program with the understanding that many questions will be coming up on both sides during this initial period of experience in a new situation. Provision should be made for meeting these problems as they arise in the everyday working situation through assignment to direct supervision. Provision should also be made for more formal interval evaluation.

A second method of individual guidance is through the supervisory conference on individual patient problems. The skill of the supervisor in allowing the nurse to develop the family situation, in securing information on how the nurse dealt with the problems, and in helping her to evaluate her service can also be used as an indirect demonstration of interview technics. From this experience, the nurse learns the importance of allowing the patient to state his problem; she learns methods of keeping the focus on the problem at hand and she learns when to allow a "side trip." The nurse learns the wisdom of not being too ready to give advice until she has enough information on which to base effective

help and until an individual has had the opportunity to indicate what steps he has already taken and what he would like to do.

In such conferences the nurse can learn to develop skill in presenting case material. She can be helped to see the need for periodic evaluation of her own work and she can be helped to develop skill in self-analysis. She can learn how to become more selective in the use she makes of the supervisory conference, taking increasing responsibility for some things herself and yet realizing that every individual has periods when they need to have help. She can learn that there is no one road to success and that it is better to offer several avenues of approach and allow the patient a choice as to which most nearly meets his needs. She will learn that the way to develop skill in supplying suggestions is to know the resources in her own agency and community. The corollary to that, of course, is that she will also learn the extent of her own limitations and those of her agency and community resources. We hope she will also realize that no one can solve all of the problems which come to her attention.

Participation in the planning of the in-service program is still another method of increasing the competence of the nurse. New ideas should be encouraged and given a fair trial. We have been satisfied with the traditional approach for too long a time. We have been rather naïve in thinking of in-service training as a "catching up or keeping up to date program." Catching up to what? Keeping up with whom? Objectives should be goals to work toward, with the full realization that performance is usually a step behind the ideal. That is as it should be for goals cannot remain static if they are to be realistic in their approach to a dynamic society.

I HAVE TRIED to indicate that individual guidance has a therapeutic role as well as an educational function in that it provides an opportunity for release of the emotional tensions which are bound to accumulate in any work situation. Certainly the field of public health nursing is not free of this possibility for no matter how congenial the atmosphere or adequate the physical environment the case load in most agencies is such that feelings of inadequacy may come to the front as a primary manifestation or may be the projection of some other area of dissatisfaction.

To be the kind of a supervisor to whom the nurse can go to "explode or let off steam" on occasion is most important. This requires good insight into human nature. It also requires sufficient insight into the pattern of the individual nurse's behavior to learn to recognize her symptoms of the "boiling point," and aptitude in dealing with its manifestations. A supervisor must be able to take as well as to give criticism, must even tolerate hostility on occasion for "the worker without a malicious bone in her body is apt to be an invertebrate."

The nurse needs an outlet of this kind but she also needs to learn to conserve her energies for its most useful application. The supervisor's handling of such behavior may help the nurse see that explosions may clear the air but are not otherwise productive. Helping the nurse think through what causes the explosion may lead her to the real factor. Directing her energies at removing the cause will "pay off" in the long run.

ADJUSTING THE evaluation pattern to different stages of experience is another consideration in individual guidance. The counselor should be skillful in making allowance for individual differences (such as age, temperament, physical status, and mental ability) in setting standards for performance, in judging the level of performance, and scaling the responsibility load for a particular nurse. As the nurse develops experience, it might be well on occasion to point out that she is taking responsibility at a level above what she had been able to do six months or a year ago. The opportunity to review records or programs prepared by the nurse when she first came on the staff and a year later, for example, might be one method of self-evaluation from which the nurse could gain insight into her own progress. As Bertha Reynolds

says, "In one sense everyone does much of his learning after the event when there is time to think things over. Since there is never a next time which repeats exactly the previous experience, there is always an unknown element as well as a portion of each successive attempt which is like the old and in which the former learnings can be used."

Not even a very abbreviated summary can be concluded without the mention of the need to keep some record of evaluation conferences. In Ruth Freeman's book, *Supervision in Public Health Nursing,* she comments on the fact that recording is considered a chore by most nurses because they do not always recognize the indirect benefits which the family receives from the written record and the fact that the problem may not be so much the recording as the manner in which the record is used.

Perhaps some day every nurse will be required to take courses and have experience in all forms of "communication," the written word as well as interviews and speech making. Attaining skill in interviewing gives the nurse a good deal of security in the field of interpersonal relationships. Ability to express herself well in writing should add to this security so that she will be willing to use records as a visual tool in interpretation and evaluation. What is written is important and we must continue to make more meaningful the material on the proficiency reports. The interpretation and use of the report are even more important.

When the relationship between the counselor and nurse has been a mutually agreeable and understanding development, the items on the formal proficiency report are not new to the nurse. The report is a method by which two people can pause to take inventory before proceeding with another expedition.

The measure of success of the individual guidance process, therefore, is the extent to which the counselor-counselee team develop a good working relationship. The nurse should develop an increasing capacity for self-help and the teacher guide an increasing willingness to allow the assumption of graduated responsibility as quickly as the nurse can carry it.

Presented at a meeting of the Public Health Nursing Section of the American Public Health Association, Boston, November 9, 1948.

APHA EVALUATION SCHEDULES

Have you been asked to participate in filling out the APHA Evaluation Schedule? If so, we urge you cooperate. If you have not been informed about this, inquire if your health department or health officer is preparing material for the schedule. This is the year the APHA will publish Health Practice Indices (last one covered 1943-1946) for which the schedules are the basis. We would like to have public health nursing information fully covered.

It is important that voluntary agencies as well as official organizations, including school nursing groups, report nursing data for schedules. They should be at APHA headquarters as soon after March 15 as possible. If you have been asked for materials, get them to your health officer. If you have not had such a request, ask NOW if your community is participating in compiling health services data for the APHA Evaluation Schedules and find out what information is wanted from the public health nursing group.

Copies of the Evaluation Schedule are available upon request from APHA, 1790 Broadway, New York 19, New York.

ADVENTURING WITH VISUAL EDUCATION

WINIFRED L. MOORE, R.N.

ONE OF THE fascinating things about public health nursing is that new avenues of learning and service are opening up year after year. This was our experience when the Board of Directors of the York (Pennsylvania) Visiting Nurse Association, with an awareness of new technics and faith in the future, purchased a 16 mm. sound projector. We planned to use it in three ways,—for staff education, for fathers' and mothers' classes, and for the enrichment of well baby conferences. The Finance Committee recommended a budget appropriation for educational purposes, to include film purchase, rentals, and incidentals, as well as the usual expenditure for outside speakers, books, magazines, and new teaching aids.

Starting with the publication "Films, Filmslides and Slides as Visual Aids . . . " issued by the National League of Nursing Education, we wrote to listed sources for catalogues of educational films. The Pennsylvania Department of Health like many other states maintains a film library and there were local sources. The Educational Film Guide, which lists selected films by subject, proved to be more helpful in our choice of material than any other reference. We started a card catalogue of promising titles, listing name and subject, source, rental fee, length of showing, color or black and white, silent or sound.

The person primarily responsible for operation and care of the projector, as well as for the rest of the visual education program, is the educational director. The nursing supervisor also is able to operate the machine, so that she can use it in her own program, or can pinch-hit for her colleague. In Pennsylvania persons operating 16 mm. machines for the public must be granted a so-called "non-theatrical" license, and must pass a simple examination, and re-register yearly. (Teachers in public schools are excepted.) The educational director holds this Class-D license.

The Board of Directors has insured the equipment against damage by fire or other accident, and have also provided for coverage of film damage incurred in operation, although most rental sources state that their fee covers such insurance. The Board has ruled, too, that projector and equipment shall not be moved from the VNA offices. Other civic groups use the room and projector without charge, or on payment of a small fee, but they must provide a qualified operator.

STAFF EDUCATION PROGRAMS

At the close of 1946 our organization like many other public health agencies was staffed by nurses quite new in the field. We were trying to acquaint them with different phases of public health nursing, particularly the communicable disease service, in which few nurses had had any experience. We used four excellent films primarily for the medical profession, but available without charge to nursing groups. A local physician recommended

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the use of a rather simple film from the York Film Library on the structure and physiology of the ear, and we showed this on the same program with "Otitis Media in Pediatrics." We showed a film on the function of the nurse in tuberculosis work, one on child health conferences, and an interesting motion picture of the Henry Street (now New York VNS) nurses in action. Other related films were the rather elementary "Home Nursing"; "Care of the Cardiac," more appropriate for institutional nurses; "Heart Disease"; and "Comeback," a rehabilitation film. When we had visual programs for other groups the staff had opportunity to view the films. If a picture was dull or ineffective we tried to discover what was wrong with it,—facts, educational method, or technical deficiency. We assessed films as to their possible use for other groups. Most films produced under educational auspices arrive accompanied by an instructor's guide. We have summarized these and duplicated the result for our staff nurses' notebooks.

Later, in the fall of 1947 we were centering staff education around industrial nursing, since we were serving four factories on an hourly basis. The program of conference and discussion was enriched by some films. "Partners in Production" showed in color how workers and management promote safety through modern mechanical guards and through observance of safe practices. "Your Eyesight" was procured from the Greater Cleveland Safety Council. This was a fine teaching film on vision, but had little on protection of the eyes in industry. The nurses asked for a picture on first aid and we showed "First Aid: Injuries and Accidents," excellent but not comprehensive. "Men and Dust" is an old documentary film on silicosis. It is a strong picture showing wretched working conditions, most of which have now been improved. Several of the nurses brought in reports on silicosis and laws covering this industrial hazard. A medical film distributed through the Harvard Film Bureau showed skin lesions from industrial causes. This is "Dermatoses of Industrial Workers." An interesting rather non-technical picture showed how individual health is protected by the use of paper cups and dishes in public eating places.

At present the staff are studying mental health at educational meetings. Fine film studies are available. "This is Robert," an 80-minute study of personality development teaches the subject intensively, holding strong attention even at the end of a busy day. Others seen recently were, "Some Basic Differences in Newborn Infants. . . . ;" Psychological Implications of Behavior during the Clinic Visit;" and "Meeting Emotional Needs in Childhood." These and others are rented from the New York University Film Library. The last mentioned is excellent for parents and for lay groups; the others almost require professional background.

From time to time, as we showed a picture which might be of interest to different groups we invited others to join us. We asked the director of public health, and the president of the local restaurant association to see the paper cup and dish film. Invitations listing the mental health films went to social workers, special teachers, and a few persons we knew to be particularly interested in child psychology. A number have attended regularly and make a definite contribution to staff education in their comments. We are scheduling still others for programs in the coming months.

CLASSES FOR EXPECTANT PARENTS

Nurses who teach these groups know how hard it is to crowd essential information into the 10 to 15 hours at their disposal. Prior to our audio-visual program we offered 7 sessions in prenatal classes, with a corresponding 3 for the men. It seemed advisable to add an additional meeting primarily for films. We already owned "Life with Baby," showing in a most entertaining fashion an overall view of the Gesell studies in child development, and "Baby Care: Feeding," a very simple and practical demonstration of formula preparation. To these we added "Care of the Newborn," prepared primarily for nurses, but of great interest to expectant parents in that it shows all aspects of preparation for and care of the new baby. We also bought two Gesell silent films on the development of feeding be-

havior, "Bottle and Cup Feeding," and "The Conquest of the Spoon." At present the mothers' classes see "Baby Care: Feeding" in a single session centered around that problem. This film was made some years ago and stresses regularity of feeding, so the nurse explains before and after the film present concepts of infant needs and self-regulation. "Care of the Newborn" is shown at the seventh class when the early physical growth of the child is the topic. "Life with Baby" forms the spring-board of a simple demonstration of child development, with two or three babies of different ages, and some toys similar to those shown in the picture for observation of personality growth. There is usually time for "Bottle and Cup Feeding," and "The Conquest of the Spoon," too. If not, the latter alone is shown.

For the fathers we use regularly "Baby Care: Feeding" for formula instruction, and "Life with Baby" for pure enjoyment, mixed with important concepts about children. These groups are quite informal, and we allow the interests of the members to be our guide. One group of men asked about a film showing the actual birth of a baby. We were not quite sure that this was advisable, so we consulted an obstetrician who had such a film, reviewed it, and decided to run it for a small group of men—the prospective mothers not admitted. This particular showing was limited to the appearance of caput and in less than three minutes, a normal birth. One man's comment was "There's nothing to it." Possibly other films might show better the processes of human birth. At present we do not expect to include films in teaching about labor and delivery.

For a number of groups we have borrowed "Bathing Time for Baby," the Walt Disney picture which has had great popularity. All classes have enjoyed it, and the teaching value is high. Time hardly permits adding this as a regular feature, even if it were always available, since we feel it does not take the place of a step-by-step explanation by the nurse followed by practice with the baby doll.

Occasionally some other appropriate picture is shown in these class groups. Their capacity for taking in topics other than those relating to pregnancy and the newborn seems to be limited. Keen and eager to see and talk about tiny babies they can hardly picture themselves dealing with later problems, so that interest and readiness to study the growing child is not there at this time. We showed last spring an excellent British film, "Your Children and You," which brings out some of the finest concepts of parent-child relationships. They found it dull. Of course another group might react quite differently.

WELL BABY CONFERENCES

The practice of including a short film on health or child development as part of the baby conference program has met with varied degrees of success. Mothers with young babies have many obligations when they get downtown,—shopping, children getting home from school, the family meal, and often they do not want to wait 10 to 18 minutes while a film which has no love interest is shown. Sometimes a baby cries, occasionally the picture is geared to a higher (or lower) degree of intelligence, and some are just not interested. The conference is a changing group as babies grow older, and regular weighing becomes less necessary. Rain or other inclement weather cuts the attendance down to four or five.

For the two past summers, from June to December, we have presented by means of films the general topic "The Child from Birth to Maturity." We have used our VNA owned films early in the program and have continued with 10 to 15 of the Gesell Child Development series, both sound and silent, adding further pictures of different aspects of child care. Some of the best of these have been "For Health and Happiness," "Let Your Child Help You," "Your Children's Ears," "Your Children's Eyes," "Tommy's Day," and "Clothing for Children." The Gesell studies are directed in general to persons on a college level, script and sound track using highly technical terms. To help those viewing the pictures the nurse takes about one minute before and double that time after the film to bring out the most important

points. In our limited space this is not easy, as people immediately begin to move about once the lights are on.

Another series of films centered around the subject of food and nutrition. At this same time the staff were having a series of conferences on "Recent Research in Nutrition at Different Age Levels." The films were in general popular in presentation, commercially produced, therefore free. Most had definite teaching value if presented by instructor-commentator. Especially good were "Something You Didn't Eat," "Strange Hunger" (shown for staff only—a film about vitamin deficiency), "Modern Milk," "The Modest Miracle," "Making Ends Meet," and "Proof of the Pudding."

COMMUNITY HEALTH EDUCATION

I have mentioned in passing unexpected by-products of the visual aid program. When we found we had a film of especially high calibre we tried to reach other persons or groups for whom it might be of value. Usually a few physicians came to observe the ones primarily medical in character. The York Junior College Sociology Class saw the documentary "Seeds of Destiny," and "Men and Dust."

Four of the more significant projects in community relationships in this field follow:

1. When we learned about the Walt Disney "Story of Menstruation" we booked and showed it to our staff, and to additional school nurses, health education teachers, YWCA and Girl Scout leaders, social workers, and one mother and two teen-age girls as guinea pigs. The film was felt to be a method of teaching superior to any presentation of this subject previously used. The school health group recommended that this be shown to the girls in junior and senior high schools, and asked that the VNA take care of the booking. In a week's time, every girl in those grades saw the picture. The subject, formerly difficult to teach, was received with interest and free discussion. One girl said, "Some girls take pills to stop menstruation; that hurts you, doesn't it?" This was only one instance among the many common problems of the growing girl which came out following the movie.

2. The promotion of the School Beginners Round-up, centered around a film "When Bobby Goes to School" which is available without charge. The story takes a mother and her sturdy 6-year-old to the family physician who gives him the sort of examination which all parents want for their children at this time. We booked the film for a week and arranged 10 showings, all at our own office, so that members of both city and county PTA's might review it. One hundred thirty-five parents representing 24 different groups saw the film and discussed it with reference to the so-called Summer Round-Up. A number requested it later to show at PTA meetings. The following year this picture was brought back to the PTA Council of the city, representing all branches, for the meeting in which plans were laid for promoting the examination. Again it was shown in city and county parent groups interested in the preparation of the child for school.

3. When we read the preliminary description of the University of Oregon film "Human Growth" we asked our schools if they planned to purchase it for their school film library. They were interested but did not care to buy it sight unseen. This fall we were able to rent it for a week, with the schools bearing the greater part of the expense. The school system had several showings,—among others for teachers, social workers, school superintendents, members of the school board, public health nurses, school nurses, parents present and prospective, York Film Council, and a member of the press. The discussion was lively, provocative, and generally favorable. The film itself is a beautiful example of classroom teaching, projecting the discussion directly to the actual observers of the film. We do not yet know the outcome of this review, but the school district plans tentatively to purchase "Human Growth" and to include it in the public school curriculum after parent groups have viewed it.

4. Another film contributing to community thinking was "The Centre," narrative and descriptive of the Pioneer Health Centre in

Peckham, a suburb of London, England. This was shown to our Board of Directors at a regular meeting. The young family whose personal problems and conflicts are evident in their contacts with the "Centre" add drama and structural unity to the documentary character of the picture. We obtained it, too, for a program of the local Social Service Club. The immediate reaction of both audiences was "Why can't we have something like that in York?"

As more persons have become aware of our use of audio-visual aids we have received more and more calls for advice, information, films (of which we own only a few), and programs. Girl Scout troops, child study groups, parent-teacher associations, clubs, special interest groups, all have had programs, borrowed films from us, or have consulted us about suitable films and how to get them. The use of movie projectors in education is increasing at a prodigious rate. The school nurses of our city and county have drawn on our experience, and we want to help them and other groups, too, in planning successful programs.

Our records are still in the formative stage, but a listing and evaluation of films shown has proved successful. We list the films by title, and number them consecutively as a new one is added; we include source, date, number of showings, number of persons in audience, cost of rental and postage, group or groups which saw it, pamphlets or teaching guides used, and finally, critical comment. We are building up, as noted above, a card catalogue of films on health subjects, child development, nursing procedures, nutrition, and other related topics. When we have finished with the film we number the card according to the consecutive list. These cards are indexed by subject, with those booked for showing kept in front of file in order of date for showing. Following use the cards are numbered and then filed back again under topic. We learn of new films through the Educational Film Guide, nursing and public health journals (infrequently), other magazines, news items, and through those shown at conventions. The *Saturday Review of Literature* carries a regular column of descriptive and analytical comment on new film issues. We have found it desirable to consult the Educational Film Guide monthly.

As new inquiries come in from different sources we realize that uses of this educational technic are still developing. Our program of visual education has brought us in touch with quite different groups who use our facilities and who take a far more definite and personal interest in our activities because of this contact. Art, nature study, religion, education, community work, and commercial photography, are special interest groups which have been brought into direct relationship with the Visiting Nurse Association of York. What the trends of this program will be as time passes we cannot tell, but we know well that the past two years' experience has been constructive, challenging, alive, and it has been Fun.

ON-THE-JOB TRAINING

How one state orients graduate nurses to the public health nursing field through short-term intensified in-service education

THEODORA A. FLOYD, R.N.

PROGRAMS TO increase the expertness of the graduate nurse by giving concentrated training on the job have been necessary in these days—and years—of personnel shortages. Pressure from county boards of health as well as individuals to place *any* nurse in a position rather than have *no* nurse are difficult to withstand. Yet it is admitted the preparation of the nurse determines the quality of service she can render.

In Georgia a committee composed of nurses on all levels, under the auspices of the Division of Public Health Nursing of the State Health Department, is developing a plan of orientation and a continuing educational program for both the public health nurse and the graduate nurse without preparation in the public health field.

What are the objectives of on-the-job training? In brief, we expect this training to enable the nurse:

1. To learn the total health needs of a community and the factors which affect the life of the individual or the family
2. To learn to adapt nursing technics to the home and other situations
3. To develop public health nursing skills necessary to render family health service
4. To become familiar with community resources and know how to use them
5. Learn to cooperate with educational, professional, and lay groups in a community
6. Create in the graduate nurse a desire for further preparation in this specialty

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How can these objectives be attained? Any pattern designed to meet them adequately falls short when the time element becomes a prime factor in planning. The time element increases in significance when the merit systems and recruitment efforts fail to fill vacancies. Many people in the county still place all nurses in one group and feel that basic nursing education prepares each nurse equally well for all types of work, while others recognize the difference and appreciate the need for developing new and special skills in the public health nursing field. Our first problem resolves about two situations: (1) the nurse who is allowed time away from her own county for orientation and (2) the nurse who must be oriented in the county where she is appointed.

The principles of introduction of the graduate to the field of public health nursing are the same in each situation, but the method and the expense involved differ greatly. Emphasis in this discussion will be on the situation in which the graduate nurse can go to a well organized county health department for a period of one month. When this is not possible, it is necessary for the regional consultant nurse to spend much more time with the nurse in her county.

Orientation of the nurse and a continuous program for her education are being developed in Georgia by a committee composed of consultants, supervisors, student sponsors, and graduate nurses. The total plan of on-the-job training is based on the needs of the individual nurse as determined by (1) studying the educational and experimental background of each (2) discussing with the nurse her needs for

assistance and (3) giving and evaluating a pretest.

The "diagnosis" resulting is used as a basis for planning the orientation and for her participation in the regular staff education program.

ORIENTATION

This might be called development of an awareness of the existing situation. It is a process of familiarization, adaptation, and learning. In Georgia there is one well developed field training center and two others which accept nurses for one month for an introductory period prior to assignment to the home county. Here the new nurse is introduced to the various aspects of public health nursing. She proceeds gradually from a short period of planned observation in clinics, homes, and schools to active participation by assisting the staff nurse with all activities. During the last week or 10 days she carries some responsibility for planning and working alone. The educational director or supervisor is responsible for the orientation and plans her program and assignment. Repeated demonstrations of new and applied technics such as bag, thermometer, concurrent and terminal disinfection, isolation, immunizations, collection of specimens, are carried out either in the conference room, clinics, schools, or in the home, under the direction of the area supervisor or the student sponsor.

The nurse keeps a diary and an activity record which she discusses with the supervisor at the end of each week in the field. She attends all staff conferences. She is given assigned readings and reports and makes field visits to the various community agencies in relation to a definite assignment. Statistical data, maps and resource material relative to her own county are made available to her to use when she reaches this stage of her development. Considerable time is devoted to learning the use of records and reports. Unfortunately the lack of sufficient clerical help in many counties makes it necessary for nurses to spend considerable time in clerical duties.

The orientation of the graduate nurse continues after she returns to her home county where prior arrangement has been made for medical sponsorship of the health program, if there is no health officer. The regional consultant nurse meets her in her county on the first day and stays as long as necessary, sometimes a week at a time, and helps her set up her office and plan her work. Together they visit the doctors, dentists, members of the board of health, county school superintendent, and other officials. Everyone concerned with the educational program is cognizant of the importance of stimulating or awakening the true spirit of service so essential to effective community work. This factor is emphasized through the orientation period as well as during the entire period of work of the nurse.

As soon as the nurse is well established in the county, specialized consultants are available through the regional consultant nurse to visit and assist her with enriching the content and technics in the specialty. This type of activity goes far in developing expertness of the graduate nurse in the special fields such as maternity, pediatrics, tuberculosis, and venereal disease.

The success of this orientation period in Georgia is attested by the large number of graduates continuing in the program and the applications which come from them seeking further educational opportunities to increase their effectiveness in the public health nursing program.

IN-SERVICE EDUCATION OR ON-THE-JOB TRAINING

In-service education picks up where orientation leaves off. One of the most effective tools for increasing the expertness of the graduate nurse is the planned staff conference. Here the graduate nurse often isolated in a rural county meets with other nurses where common problems are discussed and solutions shared. The process is democratic in the sense that staff education in each region is a product of staff thinking, planning, and action.

One joint activity during the past year has resulted in the preparation of a much needed basic procedure manual for public health nurses. Our old prewar nursing manual had not kept pace with new programs and new

ways of carrying them out. A manual committee was appointed from among the generalized and specialized consultant nurses. This group designed a plan whereby committees consisting of specialized and generalized consultant nurses, local supervisors, and staff nurses on each level worked with a chairman to develop and write various sections. This work has been a part of the content of the in-service education program in the regions. Workshop technics and group discussions were used in its development.

INSTITUTES

Local staff education programs are supplemented by regional institutes on various topics of interest to nurses and other health personnel. For example, a one-day institute on cancer was held in each of the six regions last fall. Specialists on the medical, nursing, and social aspects of the subject were utilized in this program. Earlier a two-day institute was held on tuberculosis and other institutes are planned on nutrition, venereal diseases, and pediatrics, with the purpose of increasing the nurse's expertness in dealing with these areas of service.

FAMILY CARE STUDIES

This type of presentation is very helpful because it provides an opportunity for use of the problem-solving technic. It also creates an awareness of expert nursing, or the lack of it, and methods which may provide it, such as an improved technic of the home visit, better use of community resources, and appropriate recording. The success of this method of teaching is determined by the preparation for it, the participation of all members of the group including representatives from other social agencies concerned with the family discussed, the skill of the leader of the discussion, and the security of the nurses in their relationship with the supervisory nurse.

The kind of awareness of family problems and of the family's way of meeting them, as revealed in one public health nurse's narrative, is worth noting:

Reflective thought is as essential to a nurse's professional equipment as the mastery of nursing skills and technics. A rural public health nurse has more time for meditation and reflection as she drives on a quiet, country road alive with wild life, and the evidence of man's work on the soil. When can a nurse find a better time for analysis and evaluation of a visit or a day's work.

One cold February day when I first met all three pounds of Diana—was one of those for reflection—I had heard about Diana at my first school appointment. A premature infant is always a challenge to a public health nurse's skill. From that time, I had looked forward to the moment when I could devote myself to our tiny new citizen. Even though Diana was the one on whom I had called, there was something else present which was even more evident than Diana. It was the Home. Inside of that unpainted farm house there was the warmth and reality of which Edgar Guest wrote: "It takes a heap o'living in a house to make it home." Mr. Cost, father, owner, and worker of this one-horse farm, is handicapped by nephroüithiasis. Mrs. Cost had complications throughout pregnancy which required its termination at seven months. Little Sue has frequent attacks of pyelitis and the grandmother is ill frequently. These illnesses became known to me gradualiy, shyly and with reserve, as the parents enquired about the cost of my services and the use of the incubator for their baby. This family has accepted their problems with courage, determination, and faith in themselves and the future. To them, these things are the challenge of life, of homemaking and the rearing of their children.

After finding my way back to the main road, I thought of a warmth inside that home which did not come from man-made fire. Automatically I fell to analyzing the visit. Was my approach what it should have been? Did I make my capacity clear? Did I accomplish my mission without raising any questions in the minds of the parents relative to the decisions of their doctor? Did I really teach Mrs. Cost what I set out to teach her about the care of Diana? A confusion arose as I attempted to answer these questions. Then all at once, with as much reality as if there had been a passenger in the car with me, this question was propounded:

"Did you do as much for the Costs as they did for you?"

The voice continued, "You have visited in the home of a family caught in the throes of the economy of our times—an agricultural economy. Given good weather, Mr. Cost could somehow manage to make his farm produce enough for a meager livelihood for the family, yet it is doubtful that it would cover medical needs of the group. Yet, the bad weather, the high cost of living, or medical expenses did not discourage these people to the point of making excuses for neglect, nor blaming the Lord, nor requesting that the welfare lady come out here to help them."

I felt as if I had been admitted to a preview of a life worth while. For, what is life other than the interaction, interdependence, and interrelationship of individuals? I came away refreshed in mind, enriched in spirit, and with a fresh coat of determination to meet and accept the challenges of life, both personal and professional, because I had seen an example of how it could be done. As I entered

town, I felt somehow that I knew a bit more about people, about the potentialities of human nature—not its frailties, but its strength.

FIELD TRIPS

Another method of on-the-job training, field trips—to the State Tuberculosis Hospital and the Venereal Disease Rapid Treatment Center—are particularly valuable if adequate preparation is made for them, and if the findings on these trips are used as real educational content.

The field trip is preceded by a staff conference session in which the objectives may be set up by the group and factual information on the diseases given, particularly if the nurses have had limited theory and practice during their basic training. The tuberculosis and venereal disease consultant nurses assist and have worked out a field-trip outline for use in the previsit conference. If possible they accompany the nurses in the field. And it is planned that they spend some time with the qualified public health nurses we are fortunate in having on the hospital staff and in our Rapid Treatment Center.

The staff conference following the field trip is devoted to an evaluation of the field trip, relating it to the nursing program in the field. A field trip planned and carried out in this way is highly stimulating. It results in better interpretation of the agency to the patient and his family as well as to schools and social agencies. It increases the nurse's epidemiological knowledge of the specific disease, and stimulates her interest in contact interviewing, case finding, as well as her expertness in the care of the patient when he returns to his home.

We know that much of this could be given to the nurse during her basic training. Therefore, we are working on an affiliation in tuberculosis. There is a proposal also for an affiliation in venereal diseases.

By way of summary—we are planning:

1. A month's orientation will be required for *each* nurse who has not had public health training.

2. Nurses will be admitted to this orientation at stated intervals of three months. Prerequisite for acceptance will be that the nurse meet the Merit System requirements of graduate nurse.

3. Such an experience will be planned only in counties with a well rounded program where there is a sufficient number of qualified staff nurses to be sponsors to graduate nurses and where there is an educational director.

4. The content of this program will be based on the needs of the nurses as shown by the results of a pretest.

5. The emphasis in this training program will be on family health service, the use of community resources, the use of records and referral procedures necessary to provide a complete service.

6. Effort will be made to help the nurse evaluate her own activities; to introduce her to the various supervisory technics, and condition her so that she will seek supervision rather than learn by trial and error method. This experience will be graduated so that a certain amount of proficiency will be possible in one activity before the nurse attempts the next activity. Each new activity will be broken down into the following steps—observation, analysis; preparation through demonstration, references, discussion; participation in activity; evaluation of activity; plans for next step. This method may be applied to all services as well in home, clinic, and school.

7. Individual teaching will be emphasized through each service—the nurse's own learning situation will be used as a basis for implementing the concept of teaching by "doing."

In conclusion, we hope that all these related and often complicated experiences may increase the graduate nurse's expertness in assisting families to secure what the community has to offer in the area of health improvement in an understandable way. This can be done only after we have helped her develop the type of understanding of people and their needs as was illustrated in the excerpts from one of our nurses' narratives whose "weariness had been replaced by the warmth of satisfaction of working with people and having time for reflection on their strengths."

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BUILDING EXPERTNESS IN A CLINICAL FIELD

EDNA J. BRANDT, R.N.

DURING THE last few years the fast tempo communitywide chest x-ray program has become a basic part of tuberculosis control. The excitement and glamour of this type of community activity is certainly a stimulating experience, and one which has proved the effectiveness of wide community participation. However, for real control of tuberculosis this is only the beginning. Dr. Francis J. Weber, says:[1]

> Of course, we need no reminder that the job of tuberculosis control is not done with the last screening film taken in a survey. The necessary follow up takes much longer, lacks the glamour of the initial drive, but is most important . . . All too often the patient postpones necessary hospitalization until his disease is well advanced and there results irreparable damage which could once have been easily prevented. We need not be reminded that the patient's failure to accept treatment will nullify the efforts of easy case finding.

Consideration of these facts was foremost in the minds of the city health department staff when it was decided that Seattle and King County would take advantage of an opportunity to do a communitywide chest x-ray program. This program is being sponsored jointly by the Seattle and King County Department of Public Health, the King County Medical Society, the King County Anti-Tuberculosis League, the Washington State Department of Health, and the United States Public Health Service. The nursing staff recognized that a large part of the responsibility for followup would fall to nursing, and in order to make preparation for it, request was made by the director of public health of Seattle and King County for the full-time services of the nursing consultant in tuberculosis control from the Washington State Department of Health. The state director of health approved the request with the result that the consultant is acting as liaison in the phases of the x-ray program which affect nursing. She is also assisting with the planning of the staff education program.

The first step was to determine whether or not the staff was prepared to assume its part of this task. It was felt that a program of in-service training was indicated, but where to begin? and how to place emphasis? These questions were resolved by the decision to prepare a pretest which would include the facts considered essential for the nurse to know in order to do an effective job in tuberculosis control nursing. With very little time available, as many samples of such tests as possible were obtained, and these were very helpful in drawing up the test.

The first draft consisted of 75 questions, 25 multiple choice and 50 true and false statements. Criticisms and additions were requested from several public health nursing consultants, local supervisors, and the tuberculosis clinic supervisor. It was felt by several that the test was too simple and did not contain material which would test the mature, experienced staff nurse. After collection of these criticisms the test was re-

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vised and 25 questions were added which would require more specific knowledge of the disease and current control measures. It was agreed that this addition made the test sufficiently technical to challenge and interest the entire group of nurses.

THE TEST, then, included questions on the basic scientific facts about the disease, the pathological processes caused by its action in the body, symptoms, diagnostic procedures, treatment and local facilities for care, nursing responsibilities, and control measures. Questions were worded in such a way that it would also be possible to determine to some extent from the replies, the attitudes of the nurses and their ability to use an understanding approach to the patient faced with emotional and social upheaval caused by the diagnosis. This was not too successful and we later agreed that the most effective way of determining and assisting with the building of desirable attitudes is by supervision of the individual.

Many groups of nurses were interested in the test and it was taken by a class in public health nursing at the University of Washington, the nursing staff at Firland Sanatorium, and the staff of the Health Department. All their scores and comments will be helpful in revising the test for future use. However, because of the opportunity to follow the test by an intensive in-service educational program for the health department staff, only results from that group are now reported. This was not a controlled statistical study, but some of the findings are quoted to show the method used in measuring the effectiveness of our in-service educational program.

The scores of 54 staff nurses who took the test were used for the study. Certain information regarding training and experience was requested. Each paper had an introductory sheet explaining that the purposes of the test were to form a basis for the staff education plan and to set up a yardstick to measure results of the staff education. Each nurse was asked to indicate whether her basic training had been in a three-year or collegiate school, and whether or not she held a public health nursing certificate, and bachelor's degree. Length of experience was requested under four headings—General Hospital, Tuberculosis Hospital, Tuberculosis Clinic, and Public Health. Nurses were asked not to sign their papers.

The staff was divided into two groups for purposes of study on the basis of their service load. One group, 39 of the nurses, were carrying a case load heavily weighted with tuberculosis. The area is densely populated and the sanatorium has been greatly overcrowded and not able to admit patients without a long wait. The service includes curative as well as preventive nursing, so that this part of the staff has carried a large case load of tuberculous patients for bedside care in the home as well as for health supervision. In addition they have had the benefit of approximately one year of intensive supervision from a field supervisor especially prepared in tuberculosis nursing. In this group of 39, 51 percent had had postgraduate training in public health nursing. They showed a range of from 3 months to 17 years experience in public health, 16 with less than 1 year. The average years of experience had been 6.3 with 3.3 years in public health nursing. This group averaged 28.6 errors out of a possible 100 on the pretest.

The other group of 15 nurses had not had the benefit of intensive supervision from a specialized supervisor; they were not doing a bedside program; and their case loads were less heavily weighted with tuberculosis. On the other hand they showed a higher average number years of experience, and a higher percentage with some postgraduate training. Of these 15, 93 percent had had postgraduate training in public health nursing; they showed a range of from 2 to 16½ years experience in public health nursing. The average years of experience had been 14, with 7.7 years spent in public health nursing. The average pretest score for this group was 24.4 errors out of a possible 100.

For planning the series of conferences the scores of the two groups were considered together. The range was from 15 to 39 errors, the average 26.2 errors out of a possible 100.

ANALYSIS OF THE AREAS in which the errors fell was the next step in preparation. It was observed that the errors were almost equally divided between questions on pathology and treatment, and on public health aspects and control. This analysis led to a plan for a series of 8 staff conferences, to extend over a period of about 12 weeks. The first conference, which was attended by the entire staff of Seattle-King County Health Department, was for the purpose of explaining the organization of the coming chest x-ray program, its financing, and the functions of the various participating groups.

The remainder of the series was attended only by the nursing staff. The second conference emphasized the role of public health nursing in the program. This conference brought out again many questions about medical policies, local agencies, and sources of aid to patients, which needed answering.

The third period was used for a lecture, by the medical director of the local sanatorium, which answered many of the questions on the disease and newer methods of therapy. The period following this lecture was used for discussion of nursing care of patients with clinical tuberculosis. Two areas were emphasized, protective technics to be used by persons giving care to tuberculous patients, and the need to understand better the emotional and social factors in tuberculosis.

The next three conferences gave special emphasis to mental hygiene aspects, social problems with a review of local facilities, and a discussion of the importance of recognizing how the two are interrelated. For these three conferences we were fortunate in having, to assist us, three social workers from the local health agencies.

The eighth, and final, planned conference period was conducted by the tuberculosis control officer and was a discussion of the medical policies, legal aspects of tuberculosis control, and changes in program which were indicated by the x-ray survey.

TO MEASURE what had been accomplished by this series of staff conferences, the examination was repeated, using the same questions. The staff had not been advised that the test was to be repeated at the end of the series and no particular emphasis had been placed on direct answering of the questions.

The staff was again divided into the two groups in order to grade on a corresponding scale. The first group, those from the more densely populated area, this time consisted of a total of 48 nurses whose total scores averaged 25.2 errors out of a possible 100. Of the 48, 23 had taken the pretest and attended the complete series of conferences. This group averaged 24 errors out of a possible 100 on the test, or a decrease of 4.6 over the previous test.

The other group, corresponding to the previously mentioned second group, consisted of 23 nurses, whose total scores averaged 25.6 errors out of a possible 100 on the test. Only 7 of the 23 had taken the pretest and been present for the entire series of conferences. This group averaged 28.1 errors out of a possible 100 on the test, or an increase of 3.7 from the previous test.

In explaining these results, several factors should be brought out. First, an analysis of errors indicated that those questions considered to cover the most essential knowledge for an effective job of tuberculosis control nursing which had shown high incidence of errors, in the pretest, and which were particularly stressed in the conferences, did show considerable improvement on the repeated test. One obvious factor is the turnover in staff during this period—only 30 of the original 54 who took the pretest were present for the entire series and many new members were added. This fact alone makes the results of the study statistically unreliable.

Another factor which might well have affected the result is that the staff did not participate in the planning for the program of in-service training. An in-service program can be most effectively done by a supervisor who works closely with the staff, and gains their participation in planning and conducting the conferences, as well as in correlating the material with actual problems met in rendering service. Perhaps the most logical person to do this is the generalized supervisor, in daily contact with the staff and able to obtain

technical guidance in a specialized field from a consultant.

A third factor may be that the effectiveness of a short-term intensive educational program, carried on in conjunction with a heavy field schedule, can hardly be measured in so short a period of time. It is hoped that at the end of a year, it will be possible to repeat a test on tuberculosis control nursing to this group. At that time it might be possible to see some results of this staff education program, plus generalized supervision, plus the experience of an additional case load which will probably be reaching a peak during that period.

In addition to the conferences specifically planned to meet the needs indicated by the errors in the pretest, the staff has, of course, been influenced by the widespread and constant general publicity. They have had some opportunity to participate in community organization and planning. Also the supervisors have been particularly watchful for opportunities for guidance in dealing with problems centered around tuberculosis.

A SECOND PHASE in the program, which we hope will be helpful in increasing expertness in tuberculosis control nursing, has been preparation for participation in the Retake Clinic. This type of chest x-ray survey includes screening (on 70 m.m. film) and the standard (14 x 17") film taken if there is any suggestion of abnormal findings. In case of the latter a brief history is taken for statistical purposes as well as for use by physicians in reading films and recommending follow up.

These histories are obtained by public health nurses in a short interview and the name of the physician is requested to whom the patient wishes his report sent. The nurse also answers the patient's questions and encourages him to follow recommendations in order to gain maximum benefits from good health supervision. Many times these individuals are concerned and frightened by being called back for further follow up, therefore the interviewing nurse needs to be well informed regarding tuberculosis and the facilities for care.

The staff at the Retake Clinic consists of 5 public health nurses from the regular staff who are assigned for one month each on a rotation basis in order to spread the experience to as large a group as possible. One other public health nurse is assigned permanently for the duration of the program. To prepare the staff previous to each one-month assignment, three periods of two hours are planned. The three sessions are used to familiarize the nurses with the USPHS records, new to them; explain the medical policies for referral; and learn from a social worker some of the technics of interviewing. It seems likely that this experience will greatly strengthen the staff in their ability to deal with problems in tuberculosis control nursing.

IN ADDITION to activities of the public health nursing staff above outlined, the interest and participation of all other nurses in the community, active or inactive, was stimulated by the subcommittee on nursing of the Professional Services Committee, which is in turn a subcommittee of the executive committee of the Seattle Area chest x-ray program.

The Professional Services Committee was organized, with a representative of the Medical Society as chairman, for the purpose of determining standards and medical policies for the chest x-ray program. It has representation from the medical, nursing, and social work professions. Three nurses,—chief of Division of Public Health Nursing of the State Department of Health, director of the Division of Nursing of the Seattle-King County Health Department, and a representative of the University of Washington School of Nursing faculty, were asked to serve on this committee and become the nucleus for the subcommittee on nursing. The first step in organization of the latter was to draw in representation from the local District Nurses' Association by asking the chairmen of the Private Duty, Institutional Staff, Industrial, and Public Health Sections to serve with the superintendent of nurses from each of the three local tuberculosis hospitals, supervisor of the city public school nursing staff, superintendent of nurses from the USPHS Marine

Hospital, which has a tuberculosis service, a representative from the League of Nursing Education, the health department tuberculosis clinic nursing supervisor, and the tuberculosis nursing consultant from the Washington State Department of Health.

The first activity of the committee was to clarify its functions, which were decided to be:

1. Encourage all nurses to participate in the program by having x-rays themselves, and to encourage others to do so.

2. Interpret tuberculosis nursing to all nurses in order to aid them in recognizing it as a field in which nurses have a responsibility and must be able to give accurate information in answer to the many questions nurses are asked.

3. Aid in any way possible in recruiting nursing staff for the tuberculosis hospitals which would be expanding bed capacities to give care to the active cases of tuberculosis found in the program.

The section chairmen on the committee take back to their respective groups reports on the progress of the program and information regarding it in accordance with the three aims stated.

A letter giving information was attached to the monthly newsletter which is sent by the District Nurses' Association to all its members, and the committee plans to repeat this procedure with additional information.

As a result of the committee's work, the first DNA fall meeting was given over to a discussion of the nursing and social work services which are essential to optimum care of tuberculous individuals. Immediately following, the committee arranged for two institutes on tuberculosis. These were planned for late afternoon and evening hours to meet the convenience of the greatest number of nurses. About 75 attended. The first session in each institute was a medical lecture on tuberculosis, its pathology, and newer therapies. The second was a discussion of nursing care, protective technics, special skills, and mental hygiene aspects. The last half hour of this second period was used for discussion.

The Seattle Area chest x-ray program is now well underway. We recognize that the effects on nursing will be long range and will not be over when the last miniature film is taken and the notice of its reading sent to the individual. Finding one case after another of tuberculosis, will increase case loads for several years to come, in terms of health supervision of the patients and their contacts. A method has been evolved for coding all visits made by public health nurses in the city division to any patient referred by the survey. We hope this will eventually provide data as to the increase in the case load in a generalized public health nursing program under similar survey conditions to serve as a guide to planning for public health nurse power in future programs.

We also realize that by efforts of this kind, tuberculosis will eventually be reduced to a public health problem of lesser importance. We hope that this reduction will be speeded by nurses who are well informed and confident of their ability to add constructively to this important health program.

Presented at a meeting of the Public Health Nursing Section, American Public Health Association, at Boston, November 9, 1948.

RESOURCES FOR STUDENT FIELD EXPERIENCE

Report of the Joint Committee of the Collegiate Council on Public Health Nursing Education and the Council of State Directors of Public Health Nursing on the Study of Resources for Student Field Experience in Public Health Nursing

SINCE the last report in October 1947, (PUBLIC HEALTH NURSING, January, 1948), the Joint Committee held one general meeting in Washington on December 12, 1947. At that meeting plans were outlined for the future work of the committee. It was agreed that the setting up of criteria for evaluating agencies for field experience was not an appropriate committee activity, as had been suggested. It was also agreed that the cost of student field experience programs should be determined. However, the committee did not encourage an immediate study, in view of the fact that the cost study material would soon become available from the National Organization for Public Health Nursing.

On February 20, 1948, a memorandum was sent to the state directors of public health nursing and the university directors of public health nursing programs of study asking for reports of state meetings not as yet reported to the Joint Committee. Specific recommendations on field training which might come out of these state and regional meetings were requested.

Early in 1948, the secretary sent to the state directors of public health nursing copies of the plans for purchase of automobiles in Missouri, and the Metropolitan Life Insurance Company arrangements for purchase of cars for their nurses.

Fewer than 50 percent of the state directors of public health nursing have responded to the memoranda during the two years of the existence of the Committee. From the reports which have been received, however, it is obvious that progress has been made. One state reported that an educational director was to be assigned to their field center. One university reported that a field center manual had been prepared with the assistance of the supervising nurse in the field training center. A few states reported an increase in trained personnel. The U. S. Public Health Service has had 14 public health nurses on assignment in 13 states to participate, as staff members, in the student program of local health agencies. Several states reported additional affiliations with universities for field experience in public health nursing, and some indicated that field agencies are increasingly interested in qualifying for affiliations with universities. State directors are assuming leadership in the development of new facilities and in better utilization of those already in use. There is evidence in several instances of more joint planning, with the state, university, and local agency taking part.

Transportation continues to be a real problem in field training, although some agencies have been able to provide cars for students,

Members of the Joint Committee are as follows: Helen L. Fisk, chairman; M. Irene Carn, Gertrude Church, Olwen Davies, Ruth B. Freeman, Pearl McIver, Agnes A. O'Leary, Mathilda Scheurer, Janet F. Walker, and Anna Heisler, secretary.

and a few students have acquired their own cars. It was obvious from some of the reports that a few of the agencies are beginning to feel that students may make a real contribution to the service and that the agency is therefore justified in providing transportation for them. This is not general, however, and, for the most part, the student must assume the responsibility for her own transportation.

On June 10, 1948, a memorandum was sent to the university directors of public health nursing programs of study* (and a copy to each state director) asking for specific information regarding field experience in public health nursing for students who were enrolled for a public health nursing major during the period of September 1, 1946 to August 31, 1947. This material was requested because the Joint Committee had been asked repeatedly to give information relative to field training for public health nurses, which was not available from any other source.

There has been 100 percent response from the universities to this questionnaire. A total of 35 universities responded, including the 3 basic schools of nursing jointly accredited by the NLNE and NOPHN. All have been cooperative in supplying supplementary data when requested.

The tabulations compiled from the university reports show that during the year beginning September 1, 1946, a total of 1,521 students had field experience and/or observation in 388 agencies. Of this total, 129 students had observation and work experience; 82, observation only; and 1310, work experience only.

One university used 77 individual agencies for field experience for 163 students; another university used 42 individual agencies for field experience for 180 students. There was only one university that affiliated with a single agency. The majority ranged in number of affiliations from 2 to 9 agencies; 10 universities had 12 or more agency affiliations each.

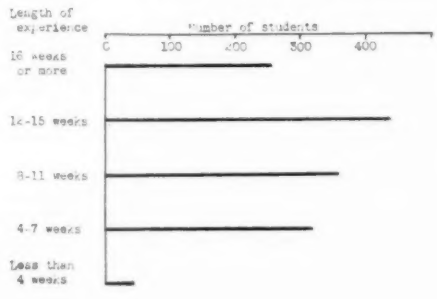
Table 1 shows by states the variation in number of universities affiliating for student field experience in public health nursing during the period studied by the Joint Committee, ranging from "none" to "3 or more." Some additional facts may be of interest: each of 7 universities had affiliations in 4 or more states; 1 of these universities had students placed in 16 states; another used facilities in 11 states.

Table 2 shows by states the variation in number of students receiving field training in public health nursing through university affiliations.

Figure 1 shows the variation in length of work experience ranging from 16 weeks or more to a period of less than 4 weeks. The greatest number of students (445) were assigned for the period of 12-15 weeks. The next largest number (372) had a period of 8-11 weeks. Roughly, one sixth of the entire group had experience covering 16 weeks or more. A negligible number (only 53 students) had a work experience of less than 4 weeks. Almost 75 percent of the group had a work experience of 8 weeks or more.

Figure 2 is shown because of the implications for all those concerned with the education of nurses. The chart shows the conclusions reached by the group attending the meeting called by Dr. Joseph W. Mountin, associate chief of the Bureau of State Services, U. S. Public Health Service, in Washington on April 5 and 6, 1948, to discuss field training for public health personnel. It represents an attempt by the group to assign the responsibility by agency for certain activities

Figure 1. Length of field experience for students in public health nursing — 1947



* Those approved by NOPHN or approved jointly by NLNE and NOPHN.

TABLE 1. UNIVERSITY AFFILIATIONS FOR STUDENT TRAINING WITHIN THE SEVERAL STATES, SEPTEMBER 1, 1946 TO AUGUST 31, 1947

State groupings according to number of university affiliations for student training	Number of states	Names of states	
TOTAL STATES	53		
States in which there are no university affiliations	14	Alaska Arizona Montana Nevada New Hampshire New Mexico North Dakota	Oklahoma Puerto Rico South Carolina South Dakota Virgin Islands Vermont Wyoming
States in which one university has affiliation(s)	15	Arkansas Colorado Delaware Hawaii Idaho Indiana Maine Massachusetts	Minnesota Mississippi Missouri Oregon Rhode Island Utah West Virginia
States in which two universities have affiliations	11	Alabama California Dist. of Columbia Iowa Kansas	Kentucky Louisiana Maryland North Carolina Virginia Washington
States in which three or more universities have affiliations	13	Connecticut Florida Georgia Illinois Michigan Nebraska New Jersey	New York Ohio Pennsylvania Tennessee Texas Wisconsin

concerned with the training of public health personnel.

Under *planning and policy* making, the federal agencies, the American Public Health Association, and National Organization for Public Health Nursing were given major responsibility, with the state, schools and foundations sharing to a lesser degree in this responsibility. In *financing and audit,* the major responsibility was placed with federal agencies, again the state, schools, and foundations sharing in this responsibility. In *specific program content,* the state, the local agencies, and the schools were given equal responsibility. Under *operation,* the major responsibility was placed upon the local agency, with the state sharing the responsibility. In *evaluation,* the major responsibility was placed with the schools and the state, with the local agency sharing. Responsibility for *accreditation* was given to the American Public Health Association and the National Organization for Public Health Nursing.

SUMMARY AND CONCLUSIONS

It is apparent from the reports which have come to the Joint Committee from the states and the universities that new resources for field experience have become available during the past two years. Just how much this has relieved the situation is not known by the committee, and can better be answered by the universities, affiliating agencies, and states.

According to the census of public health nurses compiled each year by the U. S. Public Health Service, on January 1, 1948, nurses

TABLE 2. STUDENTS RECEIVING FIELD TRAINING WITHIN THE SEVERAL STATES, SEPTEMBER 1, 1946 TO AUGUST 31, 1947

Range in size of groups accommodated in the various states	Number of states	Names of states in each range	
TOTAL STATES	53		
None	14	Alaska	Oklahoma
		Arizona	Puerto Rico
		Montana	South Carolina
		Nevada	South Dakota
		New Hampshire	Virgin Islands
		New Mexico	Vermont
		North Dakota	Wyoming
1-9	14	Alabama	Louisiana
		Arkansas	Maine
		Colorado	Maryland
		Delaware	Mississippi
		Idaho	Missouri
		Kansas	Utah
		Kentucky	West Virginia
10-49	13	District of Columbia	North Carolina
		Florida	Oregon
		Georgia	Rhode Island
		Hawaii	Texas
		Indiana	Virginia
		Iowa	Washington
		Nebraska	
50-99	5	California	Tennessee
		Connecticut	Wisconsin
		New Jersey	
100-450	7	Illinois	New York
		Massachusetts	Ohio
		Michigan	Pennsylvania
		Minnesota	

were employed for public health work in 6,550 local agencies—4,404 in rural areas and 2,146 in urban areas. From the period September 1, 1946 to August 31, 1947, only 388 agencies (fewer than 6 percent) had affiliations with universities for field experience. This indicates that there are probably many resources for field experience capable of development.

The reports do not indicate that opportunities for field experience for supervisors, teachers, and administrators have increased, nor is there any indication that workshops or other in-service preparation for field teachers have increased. The universities, the field agencies and the state directors probably know to what extent these opportunities are available. How well our present resources are being utilized is not known by the committee. It would seem, however, from the reports, (1) that more emphasis is being placed on the selection of students for field training (2) that there is some experimentation with various types of experience such as internship (3) that in some instances, joint planning by two or more agencies is being undertaken in order to provide a broad field experience for students, with one agency assuming major responsibility for the total program, and (4) that several state directors of public health nursing are taking leadership in cooperative planning with the university and the agency.

Although there are no definite figures to show the numbers of students who will need field experience each year, it would seem safe

to assume that approximately the same number that received training from September 1946 to August 1947 will need similar training for the next few years. Might it not be expected that there will be larger numbers requiring field experience from the basic schools of nursing, as an increasing number of basic schools attempt to prepare nurses for first-level positions in public health nursing? Of the 1,521 students who had field experience from September 1, 1946 to August 31, 1947, only 112 were from the three basic schools of nursing jointly accredited by NLNE and NOPHN.

Regional planning between the state director of public health nursing and the several universities sharing the field training facilities of the state, together with representatives of local agencies concerned, would seem to be advantageous, if not imperative. A university affiliating with several agencies, particularly if some are out-of-state agencies, would seem to require the services of at least one liaison nurse to carry on field negotiations and maintain effective relationships.

RECOMMENDATIONS AND SUGGESTIONS

1. That the state director of public health nursing and the university capitalize on the growing interest in local health agencies in university affiliations for field training, to improve both the service program and the educational potentialities of the agency.

2. That criteria be developed for guidance of the agency in qualifying for university affiliation and patterns be proposed for negotiating contracts between agency and university.

3. That studies be made to determine the cost of student experience (based on NOPHN cost studies) in terms of personnel—qualitatively and quantitatively—space, equipment, transportation, et cetera.

4. That the problem of transportation for students (particularly in rural affiliations) be faced squarely and that the financing of the education of public health personnel include financing of transportation for the trainee.

5. That the state director of public health nursing assume the role of leadership in promoting more and better field training in public

FIGURE 2. SUPERVISED FIELD EXPERIENCE IN CONNECTION WITH EDUCATIONAL INSTITUTIONS: Degree of Responsibility Which Should be Exercised Over the Major Phases of Supervised Field Training Activity by Various Types of Official and Nonofficial Agencies

	Type of agencies							
Phases of activity	Official state agencies	Official or non-official local agencies	Federal agencies	APHA and NOPHN	Schools	Founda-tions	Other	(Proposed) Public Health Specialty Board
1. Planning and Policy	/**	/	/****	/****	/**	/*		/
2. Financing and audit	/**		/****		/**	/*		
3. Specific program content	/***	/***			/***			
4. Operation	/**	/****						
5. Evaluation (program review)	/***	/**			/***			
6. Accreditation				/****				

Legend: / = Some responsibility to be exercised
* = Relative degree of responsibility to be exercised (4 asterisks equals maximum relative amount of responsibility, 1 asterisk equals minimum amount)

health nursing and in guiding the university to the best training facilities.

6. That every assistance possible be given by field agencies and states to schools of nursing jointly accredited by NLNE and NOPHN, in order to assist in speeding up preparation for first-level staff positions.

7. That the Joint Committee be dissolved since its immediate work has been completed, and that the NOPHN Education Committee find ways and means to give consideration to the over-all problems of field training.

Presented at the joint meeting of the Council of State Directors of Public Health Nursing and the Collegiate Council on Public Health Nursing Education, November 7, 1948, Boston, Mass.

PUBLIC HEALTH NURSING COUNCIL INSTITUTE

Across the country, thousands of community chests have raised many million dollars on the slogan "Everybody gives, everybody benefits." But this is much more than a formula for giving—it is descriptive of the complex social pattern of today. Every citizen has a stake in the health and welfare of his own community. It, therefore, follows that a board member is a public trustee concerned not only with the problems of his own agency but also with the relation of its particular effort to the total scheme of things. With the change of a word or two, the slogan is equally expressive of a fundamental principle—everybody benefits when everybody participates.

It was with this idea that the planning committee met to discuss the program for the second Board and Committee Members Institute sponsored by the Nassau County (New York) Public Health Nursing Council. How could we best serve the 28 health and welfare agencies belonging to the Council? Since "participation" was to be the key-note, the plan for the day developed logically. We would keep the program informal and practical. We would not invite outside speakers, but would use our own experts in Nassau County. The only exception was the choice of Dr. Reginald Atwater, executive secretary of the American Public Health Association, and a completely objective outsider, to act as chairman of the symposium. We would plan a time schedule so that young mothers could attend and still be home by three o'clock.

All these ideas were faithfully followed with the result that the Institute fulfilled its purpose—participation and stimulation of thought and ideas.

Our theme was, "Are community health needs being met?" The morning session was devoted to an exchange of views by three separate discussion groups: on board practices—selection and composition, organization, tenure of office, finances; on the job of being a board member—education, interest ("Are your board members 'bored' members?"), responsibility; on how we can measure the quality of our service—need, adequacy, effectiveness. After a box luncheon, brief reports were made on the morning discussions and the rest of the afternoon given over to consideration of community needs by our panel of experts, including such topics as mental hygiene, care of premature infants, and dental hygiene.

The Nassau County Public Health Nursing Council is an organized body of delegates representing 28 health and welfare agencies. Its purposes are to: interpret the work of public health nurses; promote the use of nursing services; discover county needs for nursing service; plan to meet the needs; improve the quality of public health nursing; and raise the standards of public health nursing.

MAUDE R. KIMBALL, *President*
NASSAU COUNTY PUBLIC
HEALTH NURSING COUNCIL

TUBERCULOSIS NURSING SERVICES

JEAN SOUTH, R.N.

WE HAVE BEEN concerned with the quality of service to the tuberculous and the preparation of nurses in tuberculosis control programs. Although there is growing interest in this field of nursing the information needed to define some of the problem areas has been scattered and limited. As a basis for further study the NOPHN in the 1947 and 1948 Yearly Reviews included specific questions regarding tuberculosis service and preparation of nurses.

A total of 643 agencies sent information regarding tuberculosis nursing services to the NOPHN in 1947. In these agencies 172 nurses were classified as tuberculosis nursing supervisors or nurses doing specialized tuberculosis nursing. A few of them had other responsibilities. Table 1 shows the number of nurses by types of agencies in which they were employed.

Tuberculosis Survey Work. Of the 643 agencies 52 percent assisted with x-ray surveys and 37 percent reported that they assisted in tuberculin testing surveys. Tuberculin testing in schools has not been productive as a means of case finding. *The Chest Clinic Manual* of the National Tuberculosis Association states the following regarding tuberculin testing in schools:

> This is a major activity in many communities, in fact, such work is done to the exclusion of work in other more fertile fields. Experience shows that few new cases are discovered by this type of case finding. Usually only one or even less than one significant case per 1,000 examined is discovered. It should be recognized that such surveys are largely an educational procedure and in some instances have considerable value from that standpoint. They are certain to arouse the public consciousness about tuberculosis and thereby assist in establishing a control program.
>
> School surveys may be the first organized effort in the community to assist in establishing a public service. It should be remembered, however, that they are auxiliaries in a community program and do not replace mass x-ray examinations involving more important groups or the more important contact examination and consultation service.
>
> It should further be pointed out that such surveys in school children should be restricted to the last two years in high school. The most profitable group from a case-finding point of view is the x-ray examination of the teachers and other adult employees coming in contact with students.[1]

Three hundred seventy-three agencies, or 58 percent, reported that they did the follow-up work of the chest x-ray and tuberculin testing surveys. Follow-up service was not the responsibility of all the agencies. Most authorities believe that unless there is intensive follow up, surveys are of little value. However it must be taken into account in the following table, that the follow up of tuberculin testing, for example, may have been delegated to the school nurses under the administration of the board of education, while the survey itself was conducted by the city or county health department or vice versa. Several types of agencies may help with a survey, but the follow up may be delegated to only one of the agencies, usually the official agency.

Under "other" are mentioned such activities as—referral for chest x-ray in connection with health examinations; industrial surveys; reading tuberculin tests of antepartal patients; help with surveys of general hospital patients; food handlers; barbers; house to house surveys in areas reporting high incidence; nurse conference in clinic; education in first, sixth and eighth grades tested each year; follow up of selective service examinations, et cetera. These replies show that undoubtedly some of the surveys reported as "other," should have been reported as x-ray or tuberculin testing

Miss South is tuberculosis nursing consultant in the Joint Tuberculosis Nursing Advisory Service, jointly conducted by NOPHN and NLNE. The data she discusses was collected by the Statistical Service of NOPHN.

[1] Edwards, H. R. *Chest Clinic Manual.* National Tuberculosis Association, New York, 1947, p. 52.

TABLE 1. SUPERVISORS AND NURSES DOING TUBERCULOSIS WORK

Type of agencies	Total	Tuberculosis supervisors	Other supervisors	Tuberculosis field nurses	Other tuberculosis nurses
Total	172	45	1	103	23
Nonofficial	11	4		7	
City health depts.	116	17	1[a]	75	23[b]
County health depts.	8	4		4	
Boards of education					
State health depts.	30	14		16	
Combination agencies	7	6		1	

[a] Supervisor in acute communicable disease, also tuberculosis and venereal disease nursing
[b] 22 are tuberculosis and venereal disease nurses; 1 is tuberculosis and school nurse.

surveys and follow-up services. The question in the Yearly Review may have been at fault however because it asked if the agencies participated in *mass* x-ray and tuberculin testing surveys.

Tuberculosis Clinic Work. The number of agencies which assisted in chest clinics in hospital and "outside" clinics is shown in Table 3.

More public health nursing agencies are responsible for services in clinics outside of hospitals than in hospitals. It is interesting that 7 boards of education employing nurses reported that the nurses assisted in hospital clinics.

The percentage of agencies not assisting in tuberculosis clinics or not replying to the question is high because the nonofficial and the board of education nursing services brought up the average. These agencies would naturally participate less frequently in clinic services because the control of tuberculosis is the responsibility of the official health agencies. However, in county and city health departments one third did not report clinic activities as a part of their service.

Home Service to Patients and Contacts. The number of agencies who provided home service to tuberculous patients and contacts is shown in Table 4.

Of the nonofficial agencies, 86 percent provide bedside nursing care to the tuberculous patient. It is a generally accepted practice that when official nursing agencies do not provide such care, arrangements are made with the visiting nurse service in the area to give care. The responsibility for all the tuberculosis nursing service to the family is then assumed by the nonofficial agency as it is seldom desirable to have more than one nursing agency giving service to a family at one time. Table 4 indicates, however, that this service was not always assumed by the nonofficial agencies. While 86 percent reported that they gave bedside care only 50 percent supervised contacts. We can assume that if there was a tuberculous patient in the home needing bedside care there would also be his contacts in the home needing service.

It is evident from Table 4 that combination agencies are offering a broad tuberculosis nursing service, as 90 percent were given bedside care, 90 percent were supervising contacts, and 86 percent were supervising patients following hospitalization.

Nearly 50 percent of the state health departments reported that they were giving bedside nursing care.

Ninety-seven percent of the county health departments reported that they assumed the responsibility for the supervision of contacts and 94 percent supervised patients upon discharge from tuberculosis hospitals.

Sources of Consultation Service. The sources of consultation service in the 643 agencies were as follows,—3 percent from federal agencies, 30 percent from state agencies, 7 percent from local official agencies, and 10 percent from nonofficial agencies. Six percent of the agencies did not state the source of consultant service, and 5 percent stated "other."

TABLE 2. AGENCIES ASSISTING IN X-RAY AND TUBERCULIN TESTING SURVEYS

Type of agency	Total replying	Assistance in surveys*									
		X-ray		Tuberculin Testing		Follow up		Other		Not done or no reply	
		No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
All agencies	643	335	52.1	242	37.6	373	58.0	68	10.6	200	31.1
Nonofficial	256	82	32.0	44	17.2	81	31.6	18	7.0	139	54.3
County health dept.	111	88	79.3	57	51.4	100	90.1	23	20.7	8	7.2
City health dept.	88	51	58.0	42	47.7	63	71.6	10	11.4	21	23.9
Board of education	122	76	62.3	65	53.3	83	68.0	10	8.2	19	15.6
State health dept.	37	26	70.3	21	56.8	26	70.3	4	10.8	8	21.6
Combination	29	12	41.4	13	44.8	20	69.0	3	10.3	5	17.2

* Agencies may have participated in more than one type of survey, therefore, horizontal lines do not add to 100 percent.

TABLE 3. AGENCIES ASSISTING IN TUBERCULOSIS CLINICS

Type of agency	Total replying	Assistance in clinics						Not done or no reply	
		Hospital		Outside hospital		Other			
		No.	Percent	No.	Percent	No.	Percent	No.	Percent
All agencies	643	64	10.0	205	31.9	4	0.6	397	61.7
Nonofficial	256	16	6.3	47	18.4	1	0.4	196	76.6
County health dept.	111	17	15.3	59	53.2	-	-	44	39.6
City health dept.	88	18	20.5	50	56.8	-	-	29	33.0
Board of education	122	7	5.7	23	18.9	-	-	94	77.0
State health dept.	37	4	10.8	15	40.5	3	8.1	17	45.9
Combination	29	2	6.9	11	37.9	-	-	17	58.6

Use of Special Tuberculosis Records. Thirty-five percent of the 643 agencies used special tuberculosis records; 45 percent did not; and 19 percent did not reply to the question. It is believed by many agencies that special tuberculosis nursing records are not necessary if the nursing records are designed to give space for recording significant data regarding tuberculosis. Tuberculous patients and families have the same health problems as other families and record forms which include space for recording all health and illness data are believed to help the patient and family to receive more adequate service from the nursing agency. Each nurse serving the family is more aware of the total health needs of the patient and family and her health teaching is influenced by this knowledge.

Teaching Tuberculosis Nursing. Of the agencies reporting, 57 percent indicated that teaching tuberculosis in schools of nursing was one of their activities. Special programs for graduate nurses was reported as one of the activities in 6 percent of the agencies. Teaching tuberculosis nursing to affiliating students was reported by 8 percent of the agencies. Seventy-six percent of the agencies did not reply to this question.

Public Health Nurses with Tuberculosis Experience in the Basic Curriculum and Following Graduation. Together the 643 agencies employed a total of 10,840 nurses. Sixteen percent had had tuberculosis nursing experience in the basic curriculum. Thirty-seven percent did not have this experience; and 47 percent did not reply to the question.

Twenty-three percent of the agencies had no nurses on their staffs with experience in tuberculosis nursing in the basic curriculum and 37 percent of the agencies did not reply to the question.

Seventeen percent of the 10,840 nurses in the 643 agencies had experience in tuberculosis nursing following graduation; 49 percent did not have such experience; and 34 percent did not reply to the question.

Twenty-six percent of the agencies reported they had no nurse on their staffs with ex-

perience in tuberculosis after graduation; and 38 percent did not reply to the question. The question of experience following graduation lends itself to several interpretations. Some agencies may have thought the question referred to college or university courses while others may have interpreted the question to mean experience obtained in the regular tuberculosis service in the agency.

If these figures are reliable it puts a heavy burden on the agencies to prepare their nurses to give adequate care to the tuberculous patient and his family. Tuberculosis is a major public health problem and it would appear from these data that public health nurses are ill prepared to fulfill their function in tuberculosis control programs.

TUBERCULOSIS NURSING EXPERIENCE AFFILIATING PROGRAMS

Information regarding tuberculosis nursing experience in affiliating graduate and basic student programs was obtained from 547 agencies in the sample reporting to the NOPHN in the 1948 Yearly Review. The agencies include 246 nonofficial, 134 county, 100 city, 37 state health departments and 30 combination agencies.

Table 5 shows the number of agencies with affiliating programs for graduate and basic nursing students. Comparatively few agencies are providing student affiliation in the public health nursing field.

Although tuberculosis is a major public health problem, we know that a great number of public health nurses have not had tuberculosis nursing experience in either their basic or graduate preparation. A total of 101 agencies out of the 547 stated that they included tuberculosis nursing experience in the graduate nursing student affiliating programs and 78 agencies reported that they included such experience in the basic student affiliation program. The nonofficial and combination agencies reported more students participating in bedside nursing care of tuberculous patients than the county, city, or state health departments. Nonofficial agencies arranged for 62 percent of graduate and 67 percent of basic nursing students to give bedside care to the tuberculous; official and combination agencies included bedside nursing experience in 55 percent of their graduate and 48 percent of their basic affiliation programs.

Of the nonofficial agencies 22 percent were able to arrange for basic and 31 percent for

TABLE 4. AGENCIES PROVIDING HOME SERVICE TO THE TUBERCULOUS PATIENTS AND FAMILIES

Type of agency	Total replying	Provisions of home service: Bedside care No.	Percent	Supervision of contacts No.	Percent	Supervision after hospital care No.	Percent	Other No.	Percent	Not done or no reply No.	Percent
All agencies	643	317	49.3	387	60.2	354	55.	82	12.8	144	22.4
Nonofficial	256	220	85.9	128	50.0	116	45.3	24	9.4	28	10.9
County health dept.	111	34	30.6	108	97.3	104	93.7	25	22.5	3	2.7
City health dept.	88	19	21.6	69	78.4	69	78.4	20	22.7	16	18.2
Board of education	122	1	0.8	31	25.4	17	13.9	5	4.1	85	69.7
State health dept.	37	17	45.9	25	67.6	23	62.2	4	10.8	12	32.4
Combination	29	26	89.7	26	89.7	25	86.2	4	13.8	-	-

TABLE 5. STUDENT AFFILIATION PROGRAM PUBLIC HEALTH NURSING AGENCIES

Type of agency	Total replying	Type of student affiliation programs*: Graduate affiliation Number	Percent	Basic affiliation Number	Percent
Total agencies	547	101	18.2	78	14.2
Nonofficial	246	37	15.0	45	18.3
County health dept.	134	30	22.4	12	9.0
City health dept.	100	17	17.0	7	7.0
State health dept.	37	11	29.5	6	6.2
Combination	30	6	20.0	8	26.7

* Only those agencies reporting 6 weeks or more for the student period are included.

graduate nursing students to visit "contacts." Official and combination agencies were offering this experience to 85 percent of graduate and 87 percent of basic nursing students. These figures indicate that in most instances this area in tuberculosis control is being assumed by the official agencies.

Only 3 agencies, or 3 percent, reported that graduate students gave only verbal instructions in teaching communicable disease technics; and 5 agencies, or 6.5 percent, reported that basic students gave only verbal instructions in the home. Nearly 80 percent of the total agencies reported that communicable disease technic was demonstrated in the home.

The county health departments seem to be giving graduate students more experience in all the types of activities listed in the review than city, state or combination agencies. For basic nursing students, the city health departments seem to be giving more of these experiences than the other agencies.

It should also be kept in mind that affiliating students may not have been placed in the agencies for specific tuberculosis nursing experience. Therefore, all types of activities specified in the 1948 Review might not be included in the students' programs because the students were having generalized nursing experience in the agencies.

SUMMARY

The 1947 and 1948 Yearly Reviews of tuberculosis nursing service and the preparation of nurses for it indicates that there is need for improvement. The success of control programs is dependent upon well informed and qualified nurses. X-ray and tuberculin testing surveys and follow-up services apparently are in need of re-evaluation. Tuberculosis clinics do not seem to be adequately served by generalized public health nursing agencies. City health departments were found to be assuming the greatest responsibility for this service, yet only 57 percent stated that they were assisting in clinics outside hospitals. Provision for home service indicates the need for more careful planning if tuberculous patients and contacts are to receive adequate care. The 1948 Yearly Review shows that comparatively few agencies have affiliating programs for graduate and basic nursing students. Their experience in tuberculosis nursing does not include all types of service necessary to successful tuberculosis control programs.

TEACHING VIA TELEVISION

Nurses who are interested in health education and are trying to reach large groups of parents and homemakers may well look to television as a teaching medium.

There has been a marked increase in the number of television sets now seen in the homes in all sections of New York City even though some have been purchased on the installment plan. Television sets are no longer restricted to bars, therefore, advantage can now be taken of the fact that the parents and homemakers who are unable to leave home for classes and meetings can be reached through television.

The writer recently gave a demonstration televised on how to dress an infant for cold weather, in response to requests for this information received by the television station. Other requests have concerned programs on various routine aspects of infant care, such as how to bathe and diaper a baby and how to avoid feeding problems. These requests point to the need for more informative programs geared to family interests and show that these homes are not reached by existing resources.

Public health nurses should because of their preparation and experience be the teachers best qualified for these programs as they are familiar with home conditions and needs.

This field for teaching promises to be a fertile one in which many people can be helped with an economy of effort.

ELLEN E. BLACK, R.N.
ADMINISTRATIVE DIRECTOR
JUDSON HEALTH CENTER, NEW YORK

FEDERAL HEALTH AND WELFARE LEGISLATION – 81st CONGRESS

THE YEAR 1949 is an important legislative year on two counts. First, a Federal Congress is in session which has expressed great concern for the personal health and welfare of the country's citizens. The President and Executive Branch of the Government are actively supporting a series of legislative measures designed to secure along the broad lines of social security, better living and working conditions for all. It is said that to date over 1300 bills have been introduced in Congress which pertain to health and welfare and that 60 of these have to do with health alone.

Second, the legislatures of 44 states are in session and they too are considering many forward-looking health and welfare measures.

Congressional bills of greatest interest to public health nurses will be summarized briefly from month to month. As any action is taken in regard to these or other similar bills which may be introduced later, the magazine will publish appropriate notes.

Local Public Health Units

S522 was introduced January 17 on a bipartisan basis by 5 Democratic and 5 Republican senators, and referred to the Senate Labor and Welfare Committee, E. D. Thomas (Utah), chairman. Companion bills in the House of Representatives are HR 267 (Priest) and HR 785 (Dolliver). House Committee on Interstate and Foreign Commerce will consider.

Under S 522 federal aid would be available to assist each state to establish and maintain a network of local public health units which would provide basic full-time public health services in all areas of the state. The surgeon general of the Public Health Service would decide what constitutes "basic" services, decide on the size of the area, on training necessary personnel, and on activities of the state administrative authority. Funds available to each state would vary according to state expenditures for health and to the state per capita income. Federal aid under this program would be in addition to amounts already available for special activities such as venereal disease control, cancer, and tuberculosis control.

In principle this bill is approved by NOPHN. It carries out the intent of resolutions on public health units passed by the Princeton Conference of 65 agencies cooperating in the National Advisory Committee of which NOPHN is a member. The American Medical Association approves it, also the American Public Health Association. Chief sponsors are the Association of State and Territorial Health Officers and the National Congress of Parents and Teachers. The President's social legislation program includes provision of federal subsidies to improve and expand public health services.

Aid to Professional Education

Although this topic is on the Administration's priority list of legislation, no bill has yet been introduced. When completed, however, it will probably provide, in a single measure, aid for three professional groups—medical, nursing and dental. The Federal Security Administrator two months ago held a series of conferences in Washington with these groups, to find out what they want in the way of federal aid. At the conference on nursing education on December 30, Ruth Freeman represented NOPHN.

The Committee to Study Federal Legislation of the National League of Nursing Education, on which the five other national nursing organizations are represented, has reported from time to time on the purposes to be

fulfilled by such legislation so far as nursing is concerned. Up to now the major portion of federal funds given for nursing education has been available for scholarships for graduate nurses, except those funds allotted under the U. S. Cadet Corps program and under the Social Security Act. Little financial aid has been given for the improvement of nursing education. The nursing profession now wants funds for studies leading to the improvement of nursing curriculums; for preparation of skilled staff nurses for hospital and community agencies and for private practice; preparation of educational, administrative, and instructional personnel; provision of proper educational equipment; assistance in conducting temporary demonstrations; workshops and intensive courses in nursing education; and research. Federal aid for scholarships is not sought at this time except for advanced students, but left to the states and private sources.

Nursing wants any possible federal bill to provide for a Civilian Commission to serve as a regulation and policy-forming body and in an advisory capacity to the group which administers the funds. Two thirds of the membership should be nurses.

Federal funds, nurses believe, should be distributed directly to publicly and privately supported institutions offering professional nursing education programs which have been approved by a national professional nursing organization (such as the National Nursing Accrediting Service) designated by the Commission on Policies and Regulations.

Certain principles have been outlined to govern federal aid to nursing education:

1. Federal aid must not bring direct federal control of any nursing education program. Administration of funds is done by the individual institution.

2. The federal role is secondary to that of aid from private and state sources.

3. Regulations and policies set up by the Commission should encourage experimentation.

National Health Insurance

S 5 introduced January 5 by Senators Murray, Wagner, Pepper, Chavez, Taylor, and McGrath. Referred to the Committee on Labor and Public Welfare. (S 5 replaces the old S 1320 introduced in 1948.)

HR 783 was introduced January 6 by Congressman Dingell as companion bill to S 5 and referred to Committee on Interstate and Foreign Commerce. A similar bill, HR 345 (Celler), was referred to the Committee on Ways and Means.

S 5 would provide, for about 85 percent of the people, general and specialist services, dental care, home nursing consisting of nursing care of the sick rendered in the home by a registered professional nurse or a qualified practical nurse, hospital service including necessary service, and auxiliary services and medical appliances, drugs, x-ray, radium therapy, et cetera.

Benefits would be made available as soon as possible with due regard to availability of sufficient numbers of professional and other personnel. Each state would be surveyed as to needs and a program developed to ensure maximum participation by eligible persons. If personnel is inadequate the services might be limited for a specified period.

Every eligible individual may freely select the physician, dentist, nurse, medical group, hospital or other person of his choice to render such services, provided that the chosen practitioner consents to give them. The individual makes his request direct to the physician or dentist but for other services such as home nursing is referred by the practitioner who is giving him care.

All employed and self-employed individuals and their dependents are eligible, as well as certain beneficiaries of the Federal Government. Benefits are to be made available to the needy and others not eligible when the Government is reimbursed for their care by an interested public agency.

Qualified individuals and existing organizations giving medical care will be utilized in furnishing services.

Payment for services will be provided on the basis of (1) fee for service rendered (2) on a per capita basis according to number of individuals on practitioner's list (3) salary

basis whole or part-time or (4) modifications of these approved by the state administrative agency. Rates of payment will differ in regions, states, and localities. The annual income of the practitioner will be considered and his or her degree of specialization and skill. Practitioners, including nurses, will be free to practice where they wish, and to accept or reject patients.

There shall be local administrative committees or officers, local area committees (with a majority of members representing consumers of service), and local professional committees. Wherever possible the general public health state agency will administer the state program, with the assistance of a representative state advisory committee. The state plan will provide for decentralized administration, local health service areas, and methods of selecting local committees.

A National Health Insurance Board is to be established in the Social Security Agency composed of five members—three to be appointed by the President, and the surgeon general of the Public Health Service and the commissioner of Social Security. A National Advisory Medical Policy Council of 16 is to be established—8 to be persons familiar with local needs, 8 to be professional persons, representing those providing services.

Special consideration is to be given to rural area problems and personnel shortages. A minimum annual income may be guaranteed to practitioners settling in such areas, together with transportation, personal loans, and other inducements.

A "Personal Health Service Account" shall be established in the Treasury, into which shall be paid sums equal to 3 percent of wages estimated to be received in the year—beginning June 30, 1952 and thereafter. In 1951, 1 percent of estimated national wage shall be deposited as a reserve. (The bill does not specify whether money shall come from the people as a payroll deduction or from general revenues.)

The NHI Board shall allot the funds to the states according to population, professional personnel, and service facilities. Out of these funds will be paid charges for personal health services, and administration. The Board also will administer funds for medical research and education (including nursing).

Wages as mentioned in the Act include those up to $3,600, or in case of the self-employed accrued income in that amount, but not including amounts paid out by the employer for retirement, sickness, hospital insurance, social security, et cetera.

The effective date for the benefits becoming available is July 1, 1951.

Title III of S 5 proposes to expand basic state and local public health services, maternal and child health services, services for early diagnosis of communicable diseases, and other conditions of high morbidity and mortality, services for aged, chronic, workers in industry. It provides for training personnel including nursing. Ten years is allowed each state to organize complete coverage with full-time local or district health service in each political division.

Other Health Bills

A number of bills have been introduced in the Senate and House proposing variously that special units, with large funds, be set up in the Public Health Service for arthritis and rheumatism (S 705, HR 1929, and others) epilepsy (S 659), cerebral palsy (HR 1729), multiple sclerosis (HR 2303 and others), leprosy, and influenza control. Most of these bills follow the pattern already set up in legislation enacted in previous years for cancer, heart, and mental hygiene. A National Institute would be established for the disease mentioned in the specific bill for the purpose of research as to cause, prevention, and treatment; training of special personnel; and aid of the states in the development of community programs for the control of the disease.

See page A18 for "Other Sources of Information About Health and Welfare Legislation."

EDITOR'S NOTE: Proposed legislation relating especially to children will be summarized in the April PUBLIC HEALTH NURSING.

TRENDS IN MEDICINE AND PUBLIC HEALTH

MASKS IN TUBERCULOSIS

Protection against breathing in tuberculosis germs floating in the air appears to be provided by gauze masks which have been tested at the Henry Phipps Institute, Philadelphia, according to Dr. Max Lurie and Dr. Samuel Abramson in the January *American Review of Tuberculosis*. They report on experiments carried out with rabbits wearing masks especially prepared by Esta H. McNett, R.N., of the Veterans Administration.

Miss McNett made the masks in an effort to find a means of protecting nurses caring for tuberculosis patients and exposed to infection from invisible droplets containing germs. Made of six layers of gauze, the masks are designed to filter out the germs without interfering with breathing. (Miss McNett's early experience with masks and her directions for making and caring for them, are described in detail in the January *American Journal of Nursing*.)

Testing the masks with rabbits exposed, in a specially constructed closed apparatus, to an atmosphere heavily injected with tuberculosis germs, Drs. Lurie and Abramson found the masks from 90 to 95 percent effective. Unmasked rabbits exposed in the apparatus simultaneously to the same infected air were found to be grossly infected.

Although the masks used in the experiments covered the entire heads of the rabbits, unlike masks as ordinarily worn by hospital personnel, the authors point out that masks could be adapted to human beings if fitted into a frame "constructed of pliable material which could be accurately applied to the contour of the individual's face around the nose and mouth."

"If this contact could be airtight," they continue, "there is no reason to believe that the mask could not effectively filter out the dangerous invisible particles that are concerned with the inception of pulmonary tuberculosis."

SOCIAL HYGIENE—1949

The American Social Hygiene Association, beginning its thirty-sixth active year in community social hygiene work, has issued a statement of policy for 1949 along with a review of past accomplishments. The broad objective of ASHA has been—and still is—to protect and strengthen American family life as the "basic social unit," and the nation's most valuable asset. The drive towards this objective has two specific aims (1) to build personal and family stability through the right use of sex in life and (2) to prevent and repair health and character damage which may result from the wrong use of sex. Since 1913 the program is reported to have achieved remarkable success in both directions.

In 1949, in order to maintain the gains so far made, and to extend its work even further, ASHA has set for itself the following program. It will promote a redoubled drive, by public education and community cooperation, to finish up the job of stamping out venereal diseases, which remain the nation's greatest problem in communicable disease control. It will maintain a constant alertness to the danger of a resurgence of commercialized prostitution, with prompt action when needed. ASHA field studies for 1948 show 38 percent of communities with "bad" prostitution conditions as compared with 19 percent in 1947, and 4 percent at the beginning of 1946. It will promote expanded

activities to utilize the growing eagerness of the public and of special groups, to join in the program for family life education. It will permit no letup in the year-round campaign to keep the public informed of all these developments, and working as citizen leaders alongside professional social hygiene workers in well-planned, effective community programs. During the next year the Association's national defense program will be extended, especially to include areas where young military men are most likely to be exposed to the dangers of prostitution and VD. Among these areas are the Territory of Alaska and cities on the USA-Mexico border.

For further information about program and activities write ASHA, 1790 Broadway, New York, N. Y.

WHAT IS NEW FOR THE OLD?

Recent developments in the care for the aged, particularly in New York are reported by Ollie A. Randall, in the January 28, 1949 *Better Times*. (See also PHN, February 1948, p. 61.) Newest factor in the situation is the greatly aroused interest in this once neglected group of our population, and real optimism rather than the traditional pessimism. Much of this is obviously due to the sheer numbers of the aged population. There is, however, an upsurge of positive concern and recognition that the aged are individuals with both rights and responsibilities.

What is being done for these people? Those who study the effects of population shifts say that the increasing numbers of oldsters will demand not totally different or additional services, but rather a new use of those in existence. Surgery, psychotherapy, even casework is being adapted to their needs.

There is a sporadic but nevertheless definite desire on the part of caseworkers in family agencies to learn how to individualize service to the older persons who are coming more and more often to them for help and guidance.

The Bureau for Jewish Aged in New York City is showing that the specialized approach is productive of much help to the old person, his family and the community. The bureau also is pioneering, in cooperation with one of the progressive homes for the aged, in the extension of the service and security of the home through providing a visiting housekeeper service to those who are awaiting admission but who, with the provision of the service, can continue to remain in their own homes longer than would otherwise be the case. A program of non-resident aid, by another home for the aged, is one in which living arrangements for candidates accepted for residence are made when those candidates do not as yet need the physical protection of the home but do wish the security of the knowledge that it will be available to them when and if they do need it. Some of these plans are not new, but impetus in carrying them out is new.

New York City still suffers from lack of accommodation for the "aged and chronically ill." The Goldwater Memorial Hospital for the chronically ill is one of the finest but, in the light of total need, it is not much more than a "drop in a bucket." For the disabled person who needs attendant care and personal service more than medical and nursing service, our facilities are woefully inadequate. The program of home medical care such as has been employed at Montefiore Hospital for cancer patients and a few cardiacs holds much promise. (PHN, November 1947, p. 602) The essentials of this program are that the patient remain a patient of the hospital, although removed to his own home, and that the plan be one of teamwork of the physician, the social worker, the family and the visiting nurse. Plans for a citywide home medical care program have been proposed by the Department of Hospitals. Such a plan will mark genuine progress if the program is not allowed to degenerate into a method of relieving the crowding of the hospital wards at the expense of the patient. Another promising activity is the rehabilitation program of Bellevue Hospital, based on the principle that age in itself does not prevent a return to either partial or total self-service on the part of a patient.

The establishment of the Joint Legislative Committee on the Problems of the Aging and the Aged in New York State is another of the "new for the old" projects. This committee

is concentrating its attention on the employment problems of older persons. It is also working constantly with several state departments to help promote within those departments the organization of divisions concerning themselves especially with the aspects of the state's health, welfare and labor programs which have particular reference to older groups.

Recreation for older persons is still new. Many older persons have "social adhesions" to break down as well as new habits to develop, and at an age when it is not easy to do. Play has yet to be made for them about which they will not feel guilty. For their lonely hours, companionship must be found to bring them out of their retreat. A program has been begun in New York City. So far there are 5 centers and 30 clubs throughout the city, and the New York City Department of Welfare indorses this activity through the allocation of several members of its staff to the various centers, and by arranging for the use of city-owned property rent free.

Increased medical research on the physical effects of growing old is, with new emphasis, being directed toward benefitting the aged. Several scientific societies and the U. S. Public Health Service as well are devoting money and time to research on the aging process.

Now that the shift in the age composition of our population is no longer a promise of the future but a fact of the living present, as a major social force affecting both family and personal life, it behooves us to remember that the "old age" of tomorrow can be, if we direct our efforts wisely, a new and rich experience.

CHANGES IN VA

Reevaluation of the Veterans Administration Hospital expansion program in the light of experience gained in the last 3 years indicates a need for changes, Carl R. Gray, Jr., administrator of Veterans Affairs, said recently.

Study has shown that estimated needs for hospital beds made during and immediately after the war were considerably larger than actually has proven necessary, although admission policies have been such that more than 2 out of 3 patients are admitted for nonservice-connected ailments.

On the strength of developments and based on careful restudy of 64 individual projects not yet under contract, the President has ordered a reduction of 16,000 beds, including temporary and emergency beds. To effect this, VA plans the cancellation of 24 new hospitals and reduction in the size of 14 others.

VA has currently 31 new hospitals in various stages of construction, which will provide 37,000 beds. As these new beds become available VA can close some of the temporary hospitals now in use which are operated at a cost far in excess of costs in the new hospitals. "The new building program will not result in a single service-connected veteran being denied immediate hospitalization. No changes are contemplated in the present liberal policy of hospitalization," Mr. Gray said.

Principal reasons for cancellation of proposed construction are (1) inability of VA to fully staff its present hospitals and a further definite shortage of professional personnel to staff new hospitals (2) estimated possible maximum load of service-connected patients is 51,000, leaving more than twice as many other beds available to other veteran patients (3) temporary hospitals taken over from the Armed Forces at the end of the war are remaining serviceable beyond original estimates and will not need immediate replacement as had been contemplated (4) the delay will give VA a full opportunity, in the light of experience with World War II patients, to develop further a program which meets the lasting needs of all veterans.

Mr. Gray pointed out that at present VA has 110,433 beds in its own hospitals, but due to lack of doctors, nurses, technicians and other personnel, operates only 103,533 beds with about 93,000 patients. Elimination of the proposed new beds would result in a saving of $280,000,000.

ELIGIBILITY FOR VA MEDICAL CARE

Hospitalization and outpatient treatment provided by Veterans Administration are *not*

available to members of veterans' families, VA said in response to a number of inquiries.

Many wives of veterans were treated by Army and Navy doctors while their husbands were in service. Some wives now erroneously believe they also are entitled to medical treatment from VA physicians.

Only ex-servicemen and women, if discharged under conditions other than dishonorable, are entitled to hospital treatment under the following priority system: (1) emergency cases (2) those suffering from injuries or diseases incurred in or aggravated by military service (3) those who state under oath they are unable to pay hospital charges for treatment of nonservice-connected disabilities or illnesses. These veterans, if not in the emergency category, must wait until a bed becomes available.

Outpatient treatment is available only for veterans with service-connected disabilities. Each veteran's eligibility must be determined by VA before treatment of this type can be authorized.

NURSING SERVICES IN MASSACHUSETTS

"Massachusetts has long been recognized as a leader in many phases of public health. However, there has been a considerable lag in the provision of adequate local health facilities, owing in part to the heritage of local autonomy. Our interpretation of adequate facilities is the complete coverage of the state by local health units, conducted by the official governing body of the units and financed wholly or in part with local funds. These units should be staffed with full-time, well trained personnel rendering at least basic health services to all people of the Commonwealth . . . The problem especially concerns many small communities, economically unable to provide these facilities and yet reluctant to form cooperative health units for the purpose of employing a sufficient number of trained personnel." So state Dr. Robert E. Archibald, Dr. Autino Fiore, and Dr. Solomon L. Skvirsky in the *New England Journal of Medicine*, December 2, 1948, in introduction to a critical evaluation of official local health facilities in Massachusetts.

The figures on public health nursing as a part of public health programs are of special interest.

Every community in Massachusetts has some public health nursing service administered by either official or voluntary agencies or a combination of both. There are approximately 1,379 public health nurses in the state, exclusive of industrial nurses, employed by a total of 452 agencies. This is equivalent to a ratio of 1 to each 3,379 of the population if the distribution were even. However, Boston alone has 276 nurses. Also, 44 of the school nurses are employed part time. Therefore the ratio does not indicate true nursing facilities.

There are 97 communities with school nursing service only, and 90 communities with but 1 nurse carrying on generalized nursing services. There are 123 communities with more than 4 nurses whose activities are directed by 3 different agencies. Only 18 communities have agencies with a full-time nursing supervisor.

Thus, although some of the small communities are urgently in need of more complete nursing service, many other communities have 3 or more agencies employing numerous nurses whose activities are not coordinated, whose services often overlap, and whose programs actually are at times conflicting. Poor distribution of nurses, multiplicity of employing agencies, lack of adequate nursing supervision, and the shortage of properly trained nursing personnel all combine to decrease the efficiency of public health nursing. Many nurses are employed in specialized programs that limit their nursing activities. The principle of generalized public health nursing should be adopted for greater nursing benefits and for economy. Communities and agencies should in some way pool their nursing resources and work together as one team.

NEW BOOKS
AND OTHER PUBLICATIONS

NURSES HANDBOOK OF OBSTETRICS

By Louise Zabriskie and Nicholson J. Eastman. 8th ed. Philadelphia, J. B. Lippincott, 1948. 716 p. $4.00.

The eighth edition of this maternity nursing text has retained all of the good features of former editions, such as the glossary, the self-evaluation tests, conference material, and the excellent illustrations and charts. The new edition introduces, in addition, descriptions of the frog test of pregnancy, rooming-in, erythroblastosis and the Rh factor. Mention is not made of newer conceptions in regard to childbirth without fear, cow's milk for premature feeding, early ambulation, or early discharge.

However, the text has elaborated in Unit II the social aspects of obstetrics, discussing the role of the social worker, the nurse in the prenatal clinic, and the public health nurse. Emphasis on the preventive work in pregnancy is considered in detail in relation to mental hygiene and nutrition.

This latest edition is an excellent reference and text for student nurses and for graduate nurses in hospitals, universities, and the field of public health.

—JANE Y. HARSHBERGER, R.N., *Instructor in Maternity Nursing, Boston University School of Nursing, Boston, Massachusetts.*

BLUE CROSS AND MEDICAL SERVICE PLANS

By Louis S. Reed. Washington, D.C., Federal Security Agency, U. S. Public Health Service, 1947. 323 p. Free.

This excellent compilation of information about voluntary medical care insurance in the United States is an invaluable aid to all who are concerned with this development. The study gives a wealth of detail about the size, location, and scope of the plans, and about their premiums, costs, benefits, and administrative organization that far exceeds in scope and precision anything previously compiled on the subject.

Mr. Reed also notes that, although these plans have grown phenomenally in recent years, they still fall far short of the ideal of comprehensive medical and hospital insurance for the vast majority of American people. He suggests a need for broader scope of benefits, more adequate geographical and population coverage, a greater degree of uniformity and coordination among the plans, and more adequate public participation in their control.

It is to be regretted that the study is limited to plans of the "Blue Cross" and "Blue Shield" types, and, therefore, does not give a complete picture of the variety of medical and hospital insurance programs, under industrial, private, trade union, cooperative, and community sponsorship, that form an important part of the burgeoning medical insurance movement in this country.

—DEAN A. CLARK, M.D., *Medical Director, Health Insurance Plan of Greater New York.*

CRIME AND THE MIND

By Walter Bromberg, M.D. Philadelphia, J. B. Lippincott, 1948. 219 p. $4.50.

In the preface, the author tells the reader that his emphasis is on the "phenomenology of crime, the psychology of the offender, and the emotional interrelations between the latter and his society." He is convinced that psychiatry is in a "position to assess the force of human factors involved in antisocial behavior." As the book develops, it is obvious that the author's approach to crime is that

"antisocial activity is one aspect of human behavior, rather than a specific human abnormality," and that the criminal is a "psychologically sick individual whose total life pattern is at odds with his social milieu and especially with the coalesced feelings of society as represented in law and legal institutions."

The book is subdivided into two parts: The Legal and Social Environment of the Criminal and The Individual Criminal. Each part is dynamically treated and, at the same time, definitive and succinct. Readers will find it enlightening to read the descriptions of the various kinds of psychopathic personalities. There are practically as many different kinds as there are diagnostic labels in psychiatry. The psychopathic personality was considered a major social problem in the army and is so considered in society. Dr. Bromberg repeats that present-day studies by means of the electroencephalograph demonstrate "abnormal" variations in the brain wave patterns of the psychopath. Hence, it is likely that the human constitution of the psychopath differs from mentally healthy persons.

The author is optimistic about the use of psychotherapy in treating criminal offenders, but recognizes its practical limitations. He urges a mental hygiene program which "emphasizes the individual psychological nature of criminal acts" so that a psychological environment for the understanding and treatment of the criminal may be created.

The bibliography appended to this book is particularly valuable to one interested in further study. There are approximately three hundred entries classified in three sections, namely: Historical and Legal; Sociologic and Criminologic; and Psychological and Psychiatric.

This book should be extremely interesting to the staff nurse in public health nursing whose daily contacts bring her into close proximity with many persons similar to those described, inasmuch as Dr. Bromberg points out that most of these persons are neither in jails nor in hospitals. It is only when these persons have committed a major crime that they are jailed, or when they have, by virtue of their antisocial acts, encountered a representative of the law versed in psychology, that they may be hospitalized. This book should also be most helpful to the psychiatric nurse who finds herself at her wit's end in the hospital management of the psychopath.

—Mary Schmitt, *Director of Study, Advanced Psychiatric Nursing and Mental Hygiene, 1790 Broadway, N. Y.*

TECHNIC OF MEDICATION

By Austin Smith. Philadelphia, J. B. Lippincott, 1948. 255 p. $4.00.

Intended as an aid to medical students and interns, this text can also serve as a guide to nurses in public health, private duty, and institutional work. Although containing only 200-odd pages, it interprets medicine in the broadest sense. It discusses not only the need and method of oral and parenteral administration but also the administration of treatments such as the application of medicaments to the skin and mucous membranes.

The first chapter gives a practical and stimulating over-all view of the subject. It would make a helpful adjunct to the introduction of pharmacology for student nurses. Most graduates will be especially interested in the chapter on prescriptions, the use of mails and telephones, and the legal responsibilities of the pharmacist. Pharmacology and practical arts teachers, as well as the bedside nurses, will find in Dr. Smith's book much helpful information presented from a fresh point of view.

—Louise J. Schlicting, *Science Instructor, Orange Memorial Hospital, School of Nursing, Orange, N. J.*

DISTRICT NURSING

By Eleanor Jeanette Merry and Iris Dundas Irven. Baltimore, Williams & Wilkins, 1948. 266 p. $4.00.

Those engaged in public health nursing on this continent are indebted to the authors for a reference book which outlines more fully than has been attempted before the background and practice of district or visiting nursing in the British Isles. Primarily, the

volume deals with practices adopted by the Queens Institute of District Nursing, which serves a very large proportion of the population of England, Scotland, Wales and Ireland, and may be looked upon as the prototype of visiting nursing associations in the United States of America and Canada.

Not only will visiting nurses value an opportunity to compare their concepts and methods with those of another country, but all public health nurses will find here a brief outline of legislation related to a specific nursing service including the National Health Services Act which became operative on July 5, 1948. Emphasis given the health significance of the service in all of its relationships is both encouraging and progressive.

Written primarily as an interpretation of the Queen's Institute to members of staff and to students of visiting nursing, all public health nurses will find this book a welcome addition to the literature of the subject.

—FLORENCE H. M. EMORY, *Associate Director, School of Nursing, University of Toronto, Canada.*

GENERAL

CHILDREN WITH SPECIAL HEALTH PROBLEMS: EDUCATIONAL ADAPTATIONS IN SCHOOL, HOME, AND HOSPITAL. Report of the Committee on Educational Adaptations for Children with Special Health Problems. National Tuberculosis Association, New York. 1948. 24 p. Available through state and local TB associations.

BLOOD'S MAGIC FOR ALL. By Alton L. Blakeslee. 32 p. Public Affairs Pamphlet No. 145. Public Affairs Committee, Inc., 22 E. 38 Street, New York. 1948. 20c.

EDUCATIONAL LESSONS FROM WARTIME TRAINING. By Alonzo G. Grace, et al. American Council on Education, Washington, D.C. 1948. 264 p. $3.00.

ANA PUBLIC RELATIONS WORKSHOP. American Nurses' Association, 1790 Broadway, New York 19, N. Y. 1948. 31 p. $2.50 paper bound; $5.00 cloth bound.

A manual of practical public relations technics prepared for the guidance of the national membership of the ANA.

CEREBRAL PALSY

DIAGRAMS AND DIRECTIONS FOR MAKING EQUIPMENT FOR HANDICAPPED CHILDREN—PARTICULARLY THE CEREBRAL PALSIED. Available from the Association for the Aid of Crippled Children, 580 Fifth Avenue, N. Y. $1.00.

DENTAL HEALTH

YOUR TEETH—HOW TO SAVE THEM. By Herbert Yahraes. 31 p. Public Affairs Pamphlet No. 147. Public Affairs Committee, Inc., 22 E. 38 Street, New York 16, N. Y. 1949. 20c.

HOUSING

HOUSING SITUATION, THE FACTUAL BACKGROUND. Write: Director of Group Services, Office of Administrator, Housing and Home Finance Agency, Washington 25, D. C. June 1948, available on a limited basis without charge.

LEGISLATION

FEDERAL LABOR LAWS AND AGENCIES—A LAYMAN'S GUIDE. 94 p. Bulletin No. 100. Bureau of Labor Standards, Washington, D.C. 1948.

Major provisions and purposes of all important federal labor laws and agencies serving workers and employers in quick reference guide. Available in limited quantities so long as free supply lasts.

NURSING EDUCATION

TESTS AND MEASUREMENTS APPLIED TO NURSING EDUCATION. By Hyman Krakower. New York, G. P. Putnam's Sons, 1949. 179 p. $3.50.

Teachers, supervisors, administrators in nursing education, and those in training for teaching, will find this text a carefully but simply written book on statistical measurement.

TEXTBOOK OF GENERAL PHYSIOLOGY. Philip H. Mitchell. 4th edition. New York, McGraw-Hill, 1948. 927 p. $7.50.

SCHOOL HEALTH

TRENDS IN STUDENT HEALTH SERVICE PROGRAMS. By Rhea H. Williams. *Journal of Health and Physical Education.* June 1948, v. 19, p. 387-389.

TUBERCULOSIS

IRREGULAR DISCHARGE: THE PROBLEM OF HOSPITALIZATION OF THE TUBERCULOUS. William B. Tellen. VA Pamphlet 10-27, Veterans' Administration, Washington, D.C. 64 p. 20c.

Analyzes the causes of irregular discharge and affords insight into the physical, social and psychological needs of the tuberculous.

Our Readers Say . . .

WESTERN FIELD TRIP—WINTER OF 1949

The train out of New York City was made with 6 minutes to spare. Taximan and porter gave wonderful assistance. The pullman was cold and I crawled into the upper berth after getting a pre-warming in the club car. We were two hours late getting into Chicago where it was decided that the pullman car could not be used for the rest of the trip.—so all the occupants with Mr. Stark's (porter) help juggled all the hundreds of pieces of luggage onto a clean pullman on the Exposition Flyer on another track. . . . We took off from Chicago on time and I was able to get a lower berth—more joggling. After standing for two hours, I had dinner with the man who has baked the biggest pie in the world. He produced pictures to prove his statement. A pineapple fluff and an apple pie—12 feet in diameter.

When I awoke on Monday a.m., I realized that I had not been called by the porter for it was then nearly 9:00 a.m. and we were due in Denver at 8:20 a.m. We were crawling along at a slow pace and when I pulled up the curtain, a typical mountain blizzard was in full swing. Visibility was zero and it was a bleak outlook. Somewhere along the way, the train had had to take on 100 passengers that had been grounded by a plane, so the train was full—over 400 passengers on pullmans and coaches. I had breakfast with the vice-president of the Audubon Society who is on a speaking tour with colored movies of birdlife in Maine.

After breakfast, we got into a conversation with the head of the athletic department of the University of Buffalo. The train traveled slower and slower—stopped and then proceeded about 2 miles an hour and finally stopped completely. It took us 5 hours to come the 24 miles. We were pulled onto a side track just outside of Brush, Colorado, and we soon learned that we were stuck indefinitely. Food was out and the train was getting cold. About 2:00 p.m. I decided to hike to town. I pulled out warm clothes from the wardrobe suitcase, tied up my head and finally got a group together that would make the hike. It was 10° below zero with a "wind," but we clung together and walked the tracks to the station. There I had a real experience—a "conference" with the engineer! He said that this was the worst storm that he had navigated in 45 years of railroad service and orders had been received not to move until the storm broke and a snow rotator came through. We had previously seen several herds of beef cattle huddled next to a fence—covered with snow, looking more like statues than living protoplasm.

I wired the Denver people for telephone wires were down, then we hiked up to town for food. Brush has a population of about 2,000 and had already been isolated from the West for 24 hours. Cattle herders and the town disciples were in town—standing, sitting or rocking in stores. People from the outskirts of only a few miles could not get back home. Pregnant women were in town pending possible delivery. Anyhow, we ate in a tavern-restaurant, picked up milk, chocolate, coffee, tea, and other bits, to take to people on the train. Many were headed for California with no blizzard clothes. Soon other people particularly kids returning to Colorado schools, the Navy, Army and Marines, were doing the same as we—getting into town for food. Water gave out before nightfall. I brushed my teeth in the washroom of the town tavern. A Catholic priest, the pie man, the bird man, the chief muscle boy, a female secretary of an atomic energy project and myself beat the storm back to the train for the final trip at 10:00 p.m. with more supplies.

The train was cold; the toilets frozen tight. . . . I slept warm but was up and back in the village for breakfast by 9:00 a.m. The storm was less fierce but we still sat. A group of us made rounds on the train that morning. The kitchen help was getting some food in to feed more of the people. Some were out of money, and babies had to have canned milk diluted with H_2O but they offered less complaints than grown-ups. We had one woman faint, another had some signs of shock, and one man thought he had an abscessed ear. An M.D. was finally called out from town and decided the man was suffering from altitude pressure. Morale was a little low and the state of the coaches pretty bad. A nice grandmother contributed a notebook and I started a logbook for the passengers, getting the college kids to keep it going. This was presented to the conductor. By late afternoon water was put aboard via a garden hose and coal was heaved onto the tender, so we were warm. By 6:00 p.m., food was obtained. The conductor invited us to have dinner but I thought the coaches should go first. Anyhow our mottled, cosmopolitan group finally went—boiled potatoes, peas and tough 2 inch pieces of beef, bread (no butter), and coffee. It was all right but the food did not go around for all 400.

Late that evening the snowplow got through from the East—went ahead of us and we took four hours to make the last 88 miles into Denver. I called the Olin Hotel and was assured that bed and bath were waiting. The station was quite a hubbub, people sleeping all over the place. I was so dehydrated that I spent 15 minutes at the lunch counter drinking water and orange juice. Another hour—and I was able to get a boy and my luggage out to the hotel. I spent the rest of the night washing clothes and soaking in the bath tub. It was wonderful!

LUCY BLAIR, R.N.
JOINT ORTHOPEDIC NURSING ADVISORY SERVICE
NEW YORK, N. Y.

ENGLISH JOURNEY

Yes, my English Journey was delightful. Everyone made us so welcome. We'd been strongly advised by people here that this was not the time to go, but, from England, they urged us to come. They had been through so much in the long years of war, they needed the stimulus of new faces and conversation.

All during the war, we had been sending boxes of food, but now we sent additional ones so that we would not tax their larders, and as we were to be in England over two months we were issued ration books, to be turned over to our hostesses. Probably we saw the workings of English economy better than the average American tourist, living as we did with English families in their homes, seeing their efforts to produce adequate menus with their stringent rationing and too few clothing coupons.

We landed at Southampton and went direct to London. It was a thrilling yet sobering experience to be there for the bomb damage was a constant reminder of what these people have suffered. There are areas of course that were not damaged, but whole blocks were wiped out in some places. The rubble has been cleared away but I remember seeing the side of a house still standing with the fireplaces jutting out on each floor, and high up on one mantle shelf sat a bread box. It made one realize how war came to these people in the midst of their every day life. But nature has done her best to cover the scars of war. Bright yellow flowers and rose bay willow herb make gay the desolation, even blooming on walls still standing above the shattered streets.

London is a city of monuments and we saw Florence Nightengale with her lamp and Edith Cavell looking down on the busy streets. There are always flowers at their feet.

As you know, I had to abandon my plan for doing public health observation. However, I talked with public health nurses when I met them on busses or trains or on the street. Many of them ride bicycles. They wear a dark blue uniform and frequently no hat, for who would use coupons for hats when sheets, towels, curtains, and many other household articles must come out of clothing coupons. Their work is very like ours. Their Health Centers are well organized. These nurses have done a splendid job in a wartorn country and are still working under adverse conditions of shortages and privations. I learned from them that the long enforced rationing has had its effect upon the people. There is a marked increase of illness in the aged group. Tuberculosis is on the increase and whooping cough is six times more prevalent than measles. Proof that they have kept up immunizations despite the war is demonstrated by the fact that diphtheria is less than one fifth the prewar rate.

One nurse that I met at Berwick-on-Tweed was attached to a mobile x-ray unit. She is one of a staff of 8—a doctor, 2 nurses, and technicians. They have recently increased the number of these units working over the country. It seemed familiar to hear her say that they were making a survey at the shipyard. Follow-up work is done by local public health nurses. I saw some of the modern health education in London, lectures, movies, and exhibits. Some were free; others charged a small admission fee. The movie titles and hours were posted and there was a change of picture daily. I saw several and they were excellent.

The children look very well. All pregnant women and young children are issued special ration coupons. They are also given first chance at any fruit that may be available. Cod liver oil, orange juice, and powdered milk are given out from the Ministry of Food Office to all children under 5 years. Points from their ration books are given up for these items, but no money. The orange juice comes in a bottle, is bright yellow and quite thick, but they say that the children love it. The nurses are very proud of the fact that the infant and maternal mortality rates are at a new low.

You might be interested in some of the items in a week's rations for an adult. One egg, 1 ounce of cheese, 2 ounces of butter or margarine, small amount of meat—about 20 cents worth, about 2 ounces of sugar, and the same of tea. A three-course dinner consists of soup or bread, meat or a substitute, a vegetable, and a sweet. They try to pad this out with vegetables and chickens.

That the long war and the austerity of peace have definitely undermined the stamina of the people was pretty clearly demonstrated this summer. England lost in the cricket match with the Australians and in the Olympic Games. The stamina of the horses was affected by the shortage of oats and they too lost in the international races. But I hope it will not be too long now before conditions are better. While we were there bread came off the rationing and sheets and stockings.

We had relatives and friends scattered all over England, so that we were able to see pretty much of the whole country and had many interesting experiences—tea with Lady Cripps at 11 Downing Street, a special service at Westminster Abbey, and the glories of many cathedrals. I shall never forget standing by the graves of the Black Prince, Shakespeare, Nelson and Florence Nightengale,—men and women whose lives shaped through stress and strain, through wars and victories, the destiny of the English people.

Then too the memorial in York Minster. It was dedicated to the women of the Empire who gave their lives in the war and was inscribed with the words of Edith Cavell—"Standing as I do in the view of God and eternity, I realize that patriotism is not enough. I must have no hatred or bitterness toward anyone." What a marvelous woman she was and what a country that can produce nurses like that!

Indeed it was a wonderful trip and as one old lady said on my return, "It will be wood for winter fires."

CHARLOTTE M. INGLESBY, R.N.
SAVANNAH, GA.

FROM NOPHN HEADQUARTERS

ASK NURSES TO STUDY NEW STRUCTURE PLANS

Nurses will be asked to consider and decide between (1) a two-organization plan and (2) a revised one-organization plan for the structure of organized nursing just as soon as a study handbook can be made available.

The decision to present two plans for the profession to study was voted unanimously by the boards of directors of the six national nursing organizations sponsoring the structure study following a joint meeting of those boards and the Committee on Structure in New York January 27. The six boards were also unanimous in voting for a proposal made by the American Nurses' Association that wide publicity among nurses be given the reasons why five of the boards recommended the two-organization plan.

The two-organization plan was recommended by the Boards of Directors of the National League of Nursing Education, the National Organization for Public Health Nursing, the National Association of Colored Graduate Nurses, the American Association of Industrial Nurses, and the Association of Collegiate Schools of Nursing. The Board of Directors of the American Nurses' Association favored the one-organization plan because ANA members have, at two House of Delegates meetings, indicated their interest in one organization.

REASONS FOR TWO ORGANIZATIONS

Reasons why the five organizations recommended a two-organization plan include the following:

1. Nurses and their public need organization machinery through which they can work actively together toward the betterment of nursing services. The need is particularly great just now when recommendations in the Brown Report and in plans of both voluntary and governmental agencies for expansion in all fields of health services point to major changes both in schools of nursing and in nursing services. Nurses must and will have their all-professional organization through which to work on all matters of concern to a professional group, and this professional organization must be as deeply concerned with the service needs and resources of the community as it is with the welfare of individual members. At the same time, the boards of the five organizations believe that it is necessary to offer non-nurses voting memberships in an organization to achieve the desired cooperation.

2. It is not possible now for a single national nursing organization to offer voting memberships to non-nurses and at the same time to continue membership in the International Council of Nurses, which all nurses wish their professional organization to do. The Board of Directors of the ICN, meeting in London in September 1948, postponed decision on the question of whether or not an organization with non-nurse members in divisions as proposed in the 1948 "Tentative Plan" could be admitted to ICN membership. Though members of the ICN board said they did not think the "Tentative Plan" was in conflict with the ICN constitution, since nurses would control the proposed organization, nevertheless, in light of fears of interference from outside the profession expressed by nurses from some countries, it was decided not to press for a decision at this time.

3. It is not possible for a single corporation to engage in a legislative program that involves lobbying in the interests of organization members and at the same time to receive contributions which the donors may deduct for income tax purposes. It would obviously be important for a nurses' organization to be

free to work for or against any legislation, whether national, state, or local, that it wished. At the same time, gifts from foundations and others will be essential to an ongoing program in nursing. Foundations gave over $400,000 to nursing through the National Nursing Council and it seems probable that other such gifts are available if nursing has satisfactory channels through which to receive and administer them.

4. Another aspect of the incorporation question is the fact that the education and service part of a national nursing organization should be able to look to nursing agencies for increasing support. Most voluntary public health services and many hospitals receive Community Chest funds. It is essential that any national organization expecting to receive dues from agencies which, in turn, receive support from Community Chest funds should establish tax-free status.

5. To continue the help now being provided by existing organizations to nursing services and to schools of nursing, and to extend that help as required to maintain and build up standards during the era of change that doubtless lies ahead, it is essential to offer memberships to agencies and schools. This requirement involves (a) the need for an organization with a tax-free status as discussed just above and (b) the possibility of offering voting memberships to the many non-nurses as well as nurses who compose boards, facilities, and staffs of such agencies and schools.

STUDY OF NEW PLANS

While the time schedule for the structure program was left for the Committee to decide, the boards accepted the committee's own recommendation that its existence be terminated by the end of 1949. Some of them appended the stipulation "if its work is completed."

The committee hopes that the handbook can be ready by early March. Enough copies will be sent to state units of all six organizations participating in the structure study to assure free distribution of at least one copy to each local unit. The basis upon which other copies can be supplied will be announced later. The committee's aim is to secure the widest possible distribution and discussion.

Boards and committee again stressed the importance of organizing or revitalizing, all over the country, state and local structure committees that include representation from all groups similar to those cooperating nationally in the structure study, and all major types of nursing being practiced in the area. These committees are asked to organize meetings at which the new structure plans will be discussed from various points of view.

Meetings of separate groups should be utilized for structure discussion, but every effort should be made to have at least one representative from each of the various groups present to help complete the picture.

Both of the new plans are variations of the "Tentative Plan" published in the May 1948, *The American Journal of Nursing* and elsewhere.

TWO-ORGANIZATION PLAN

The two-organization plan differs from last spring's "Tentative Plan" chiefly in that there would be two separate corporations:

1. An organization to which only nurses would belong would be incorporated as the *American Nurses' Association,* to:
   a. Include occupational *sections,* which would among other things serve as bases for proportional representation of different nurse groups in the governing bodies, and *councils* made up of clinical specialists. The 1948 Plan suggested that occupational and clinical specialty groupings of nurses all be called *sections.*
   b. Offer an *Assembly* to afford direct *voice* at biennial conventions to any member wishing to express an opinion.
2. The divisions proposed in the "Tentative Plan" would become a separate corporation, the *Nursing League of America,* with nurse, non-nurse, agency, and school membership.

Further differences are:

3. To coordinate activities of mutual concern to the new ANA and the new League, a joint board is proposed, made up of representatives from the boards of the two organizations.

4. Part of the headquarters services would be under supervision of the professional organization; part under the joint board; part under the education and service organization.

ONE-ORGANIZATION PLAN

The new one-organization plan would use the name American Nursing Association as did last spring's "Tentative Plan," but it would differ from it in that:

1. Membership in *forums,* which would be *discussion bodies* with only *advisory powers* in relation to the American Nursing Association, is offered to non-nurses and agencies instead of membership in the overall association, as proposed in the 1948 plan.
2. The 1949 one-organization plan would give voting membership in the American Nursing Association *only to nurses.*
3. The same provisions for Assembly, sections, and councils as indicated for the American Nurses' Association in the two-organization plan would be made for the American Nursing Association in the one-organization plan.

The single organization would undertake a comprehensive program for nursing, but would be subject to the considerations stated earlier in the five reasons why the five organizations recommended the two-organization plan.

Details of both plans will be presented in the handbook, and this magazine will offer charts and a condensed version of the two plans as soon as the Committee on Structure makes them available.

INTEGRATION PROJECT

Lucy Blair, NOPHN consultant on the Joint Orthopedic Nursing Advisory Service staff, is participating in a demonstration project on integration of the principles of posture and body mechanics in nursing education at the University of Colorado School of Nursing, Denver and Boulder, Colorado. During the winter semester the faculty plan to review curricula in order to learn needs and develop methods on correlating and integrating these principles in the graduate and basic nursing programs. (See also page 169.)

BASIC CURRICULUM JOINTLY ACCREDITED

At a meeting held February 10 the NOPHN Committee on Accreditation granted accreditation to the Cornell University-New York Hospital School of Nursing which conducts a basic professional nursing curriculum. This constitutes the fifth such school jointly accredited by NOPHN and NLNE. The others are Skidmore College Department of Nursing —New York Postgraduate Medical School and Hospital (accredited in 1944), Vanderbilt University School of Nursing (1945), Yale University School of Nursing (1945), and University of Washington (1948). Virginia M. Dunbar is dean of the Cornell-New York Hospital School of Nursing.

JANUARY REPRINTS

Reprints from the January magazine will soon be ready—"Problems of Colostomy Patients" (20 cents) and "Nurse and Nutritionist Work Together" (15 cents). Single copies are free to members of NOPHN. As previously announced a reprint of the four articles on physical therapy including Jessie L. Stevenson's introduction may be obtained from the Joint Orthopedic Nursing Advisory Service at 1790 Broadway without charge.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Anna Fillmore	Albany, N. Y.—Mar. 1 Washington, D.C.—Mar. 8
Lucy E. Blair	Denver and Boulder, Colo.—March
Hedwig Cohen	Indianapolis, Ind.—Mar. 25, 26
Ruth Fisher	Charleston, W.Va.—Mar. 21, 22
Dorothy Rusby	Peoria, Ill.—Mar. 10-19
Jean South	Baltimore, Md.—Mar. 7-10 Washington, D.C.—Mar. 11 Cleveland, O.—Mar. 31
Louise M. Suchomel	Newark, N. J.—Mar. 18 Winnipeg, Can.—Mar. 27-Apr. 2

February field trips included visits to Rochester, N. Y., by Dorothy Wiesner, and Washington, D. C., by Mary T. Collins.

NEWS AND VIEWS

FROM FAR AND NEAR

JOINT BOARD OF SIX

A step forward in cooperative thinking and action was taken on January 29 when the Joint Board of Directors of the six national nursing organizations was formed. Members are NOPHN, AAIN, ANA, ACSN, NACGN, and NLNE. The new board succeeds the joint board of ANA, NLNE, and NOPHN which voted itself out of business just previous to the formation of the new group.

The national nursing organizations have long worked together in matters of mutual interest, ANA and NLNE cooperation going back to the last century. First meeting of the NOPHN Board with the other two boards (NOPHN was founded June 7, 1912) appears to have taken place October 23, 1912. First biennial convention of the three was in 1920, in Atlanta, Georgia. Joint headquarters were first occupied on May 1, 1921 at 370 Seventh Avenue, New York City.

Wartime needs demonstrated that national nursing affairs required joint action in which not only the three organizations would participate but other organized nursing groups, the federal nursing services, and medical, hospital and consumer representatives as well. The National Nursing Council grew out of this need. When the Council wound up its affairs in 1948 its most important activities had been turned over either to one of the member organizations or to joint committees. Several of these committees had representation from the six organizations but no overall body to which they could report. For this reason and because there was general need for a mechanism by which the boards of the six could discuss common projects together, the new Joint Board was organized.

Rules of procedure were accepted at the January meeting. Duties of the Joint Board are to (1) create joint committees (2) decide upon their functions, operation, budget, et cetera (3) request one member agency to assume administrative responsibility and (4) dissolve joint committees. Between meetings of the Joint Board, a Reviewing Committee will review joint projects, recommend committee appointments and paid staff, prepare committee budgets, and otherwise facilitate committee action.

RECRUITMENT PROGRAM—1949

Representatives from allied professional groups, educational organizations, and consumers of nursing care comprise the enlarged Committee on Careers in Nursing, sponsored by the six national nursing organizations, which last month assumed the responsibility for guidance of the student nurse recruitment program. In announcing the membership of the committee, and its widely representative character, Theresa I. Lynch, chairman, points out that the American Hospital Association, which spearheaded the national recruitment program for the past two years, will continue to participate in the planning through its membership on the committee. It will also continue to make available for 1949 the materials,—public relations guide and kits, mailing piece, posters—which were prepared for last year's program.

Commenting about materials, Miss Lynch said "Recruitment groups in the states will find the materials prepared for the 1948 campaign equally useful in 1949. These may be supplemented by the folders available from the Committee on Careers in Nursing. A

limited budget this year of approximately $18,000, provided by the nursing organizations and the American Cancer Society, in contrast to budgets three or four times greater used by AHA in the 1947 and 1948 campaigns, makes it possible for the Committee on Careers to offer guidance to local recruitment groups as well as some materials, including new folders. Continued year-round recruitment by all local groups is essential to maintain or surpass the 1948 record peacetime enrollment of 43,373 students in schools of nursing."

Approval of the plan for the Committee on Careers in Nursing to assist local recruitment activities, within the committee's limited resources, was voted at the meeting of the Joint Board of the six national nursing organizations on January 29.

Emilie G. Sargent, executive director of the VNA of Detroit, is the NOPHN representative on the committee.

● The National Tuberculosis Association will hold its annual meeting in Detroit, May 2-6. The conference on nursing which has become a feature of the occasion will be held Monday, May 2, from 2-4 p.m., at the Book-Cadillac Hotel. The theme is "Safer ways in nursing to prevent the spread of tuberculosis" and there will be a symposium with panel and audience participation, Don Phillips as leader. The two topics for discussion will be selection of protective measures and responsibility for safe practices. Speakers on the first topic include W. G. Childress, M.D., and Almira Hemstead, R.N., and they will try to answer such questions as: Can activity of disease and sputum status be used to advantage as a basis for selecting protective measures? What is the significance for nursing services? Rosella Schlotfeldt, R.N., will speak to: Can responsibility for protective practices safely be transferred from nurse to patient? and Ruth C. Farmer, R.N., and Bess M. Ellison, R.N., to: What criteria can be used as a basis for sharing responsibility for safeguards?

Nurses interested in tuberculosis will find the meeting friendly, stimulating, and a valuable source of information on current research in this field. See March *Bulletin* of the NTA for the full program. Consultants from the Joint Tuberculosis Nursing Advisory Service of NOPHN, NLNE, and NTA will be available for conferences during the week.

● National Negro Health Week will be observed April 3-10. The objective is "Cooperate with your health agencies and your neighbors for better health and sanitation in your community."

● An advanced six-week course in rehabilitation methods for physical therapists will be offered by the Institute of Rehabilitation and Physical Medicine of the New York University-Bellevue Medical Center in conjunction with the NYU School of Education, under the supervision of Dr. Howard A. Rusk, Dr. George G. Deaver, Dr. Donald A. Covalt, Edith Buchwald, and Beth Addoms. The first course will be from February 9 to March 22, and the second course will be from April 4 to May 13.

The course will consist of both didactic and clinical instruction in testing and advanced training in the activities of daily living, the practical problems of ambulation, elevation, and self-care.

Further details can be obtained by writing Edith Buchwald, Institute of Rehabilitation and Physical Medicine, 325 E. 38 Street, New York 16, N. Y.

● Dr. Howard A. Rusk will deliver the annual Herman M. Briggs lecture at the New York Academy of Medicine, April 7, at 8:30 p.m. The subject of the lecture will be "The Medical, Social, and Public Health Aspects of Rehabilitation." The public is invited to attend.

● The 45th Annual Conference of Health Officers and Public Health Nurses will be held at Lake Placid, June 20-23, 1949. The Association of School Physicians will hold its annual meeting on opening day in conjunction with the general conference of public health administrators.

● The International and Fourth American Congress on Obstetrics and Gynecology, sponsored by the American Committee on Maternal Welfare, will be held May 14-19, 1950, at the Hotel Statler, New York City.

Inquiries pertaining to the meeting should be addressed to Dr. Fred L. Adair, Chairman, 24 W. Ohio Street, Chicago 10, Illinois.

● National Boys and Girls Week marks its 29th annual observance this year from April 30 to May 7. The theme is "Building for Citizenship," and the program is designed to focus public attention on the interests, activities, and problems of youth. The suggested program for Tuesday, May 3, is "Health and Safety."

To Every Nurse

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these important McGraw-Hill books which should be part of the well-chosen nursing library

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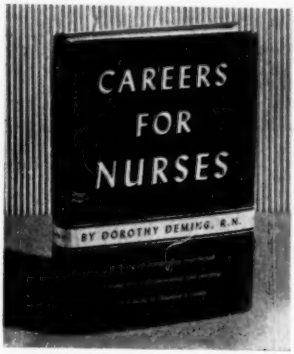
By DOROTHY DEMING, R.N.



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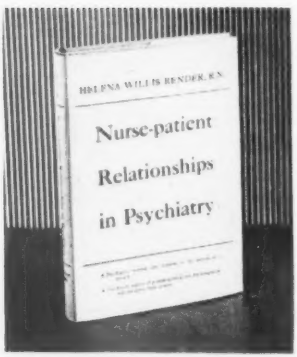

NURSE-PATIENT RELATIONSHIPS IN PSYCHIATRY

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Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

With **TRUSHAY** *that is.*

For TRUSHAY starts off by being the most luxurious softener that ever smoothed your skin—rich as cream—but without a trace of stickiness. It's sheer delight to use at any time.

And that isn't all.

For TRUSHAY does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, TRUSHAY protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

Begin today to use TRUSHAY—and when patients admire your well-groomed hands, tell them about the lotion with the

"beforehand" *extra—*

TRUSHAY

Product of BRISTOL-MYERS • 19 West 50 Street, New York 20, N. Y.

RESEARCH SHOWS HOW YOUR PATIENTS CAN HAVE GOOD FOOD AT LESS COST

Full year field check by 19 Universities* on 12 commonly used Fruits and Vegetables in their four marketable forms —Fresh, Frozen, in Glass and in Cans—provides significant data on meeting today's living costs.

During recent years food costs have taken an ever-larger share of family budgets. What can your patients and other American homemakers do about it?

Seeking an answer to the problem, 19 American universities conducted a research project—October, 1946 through September, 1947—on the cost and availability of 12 commonly used fruits and vegetables. Results of this research boil down to this: *Penny for penny canned foods in general give consumers more food for their money, as well as more nutritional values. Most foods in cans cost less than the same foods in glass—less than fresh foods—and far less than frozen foods.*

SOUND RECOMMENDATION

Results of this pioneering coast-to-coast research again show the importance of canned foods in relation to improved national nutrition. The more closely you study the known nutritional values of foods in cans, their *high* percentage of year-round availability, and their *low* cost generally, the more justified will you feel in recommending them to patients who look to you for guidance.

FREE

Booklet giving full details of the Comparative Cost and Availability Study on 12 fruits and vegetables. Copies of previously published booklet, "Canned Foods in the Nutritional Spotlight" are also yours for the asking.

Please send me, free of charge,_____copies of the new booklet entitled: "Canned Foods in the Economic Spotlight."

Name_____

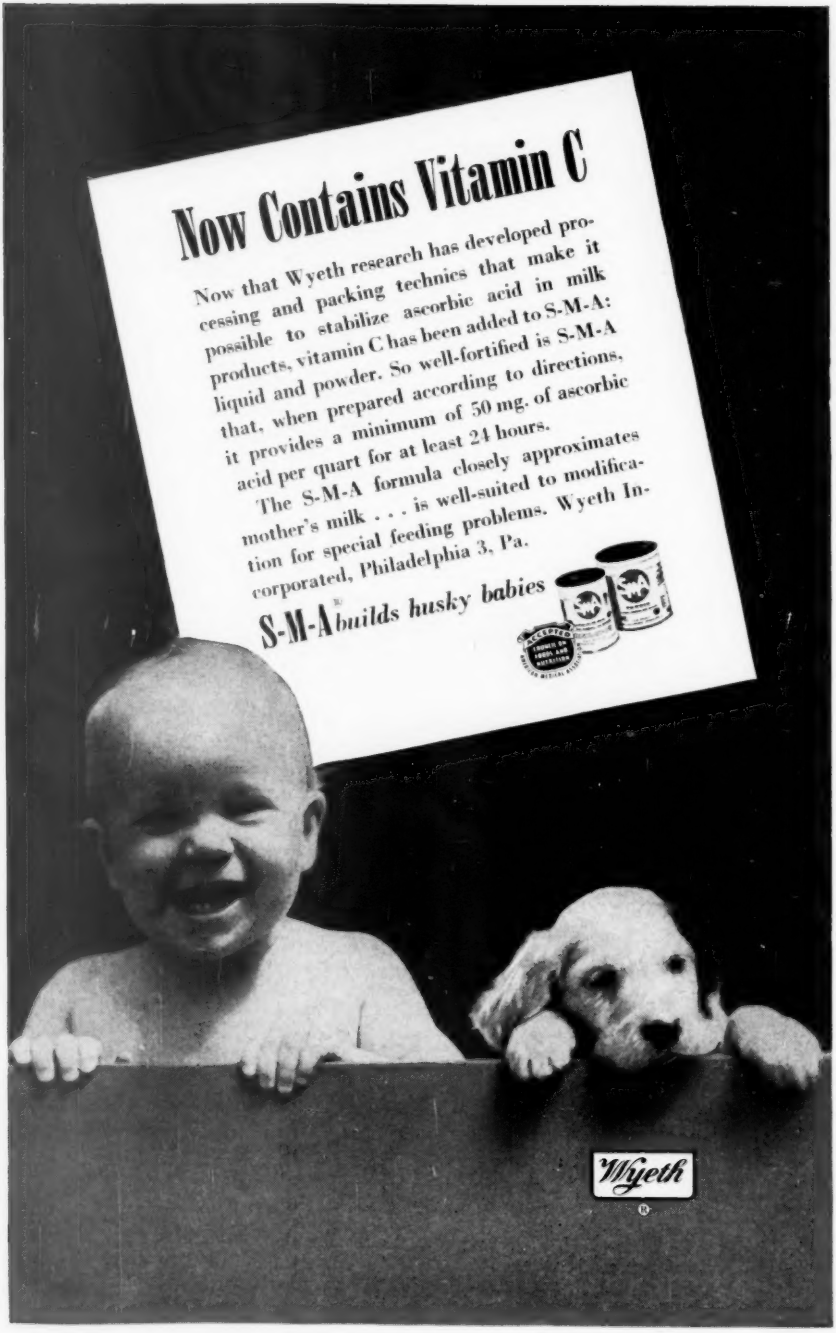
Address_____

City_____ Zone____ State_____

☐ Also send.....copies of "Canned Foods in the Nutritional Spotlight."

For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April, 1948 issue of the Journal of the American Dietetic Association.

CAN MANUFACTURERS INSTITUTE, INC.
60 East 42nd Street, New York 17, N.Y.


Now Contains Vitamin C
Now that Wyeth research has developed processing and packing technics that make it possible to stabilize ascorbic acid in milk products, vitamin C has been added to S-M-A: liquid and powder. So well-fortified is S-M-A that, when prepared according to directions, it provides a minimum of 50 mg. of ascorbic acid per quart for at least 24 hours.
The S-M-A formula closely approximates mother's milk . . . is well-suited to modification for special feeding problems. Wyeth Incorporated, Philadelphia 3, Pa.
S-M-A® builds husky babies
ACCEPTED
Wyeth

MEAT...

In the Rational Weight Reduction Program

One dictum is universally recognized in the planning of reducing diets: the basic requirements of good nutrition remain unaltered, and adequate amounts of high-quality protein are the cardinal factor in the successful dietary management of overweight.

Protein allowance in such a program is stated to be not less than 1.5 to 1.7 Gm. per Kg. of ideal body weight.[1] A further advantage of the diet high in protein and low in fat and carbohydrate is its greater simplicity; the tedious calculation of calories may be omitted without impairing the efficacy of the program.[2]

It is therefore recommended that lean meat be given a dominant role in reducing diets.[1]

The protein content of meat is notably high. Regardless of cut or kind, meat provides biologically complete protein able to satisfy the multiple amino acid needs of the body.

Lean meat, particularly, is of excellent digestibility. Its outstanding satiety value assures patient cooperation, a vital factor in the success of any weight reducing program.

---

[1] McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 4, Philadelphia and London, W. B. Saunders Company, 1943.

[2] Kunde, M. M.: The Role of Hormones in the Treatment of Obesity, Ann. Int. Med. 28:971 (May) 1948.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago...Members Throughout the United States

OTHER SOURCES OF INFORMATION ABOUT HEALTH AND WELFARE LEGISLATION

Copies of bills can be secured from the Superintendent of the Documents Room, in either the U. S. Senate or House of Representatives, Washington 25, D.C., depending on whether the bill desired is a Senate or House bill.

Many national professional, and citizens' organizations are studying and making recommendations in relation to specific legislative proposals. Their published materials are available on request.

The following periodicals regularly publish summaries and comments on legislation:

Social Legislation Information Service

This Bulletin reports impartially on federal social legislation and the activities of federal agencies affecting family life, children, and community services in the areas of health, education, welfare, housing, employment and recreation. The Service takes no position for or against legislation.

Social Legislation Information Service, 930 F Street, N.W., Washington 4, D.C. Annual subscription is $15. Special offer to new subscribers, $10 per year.

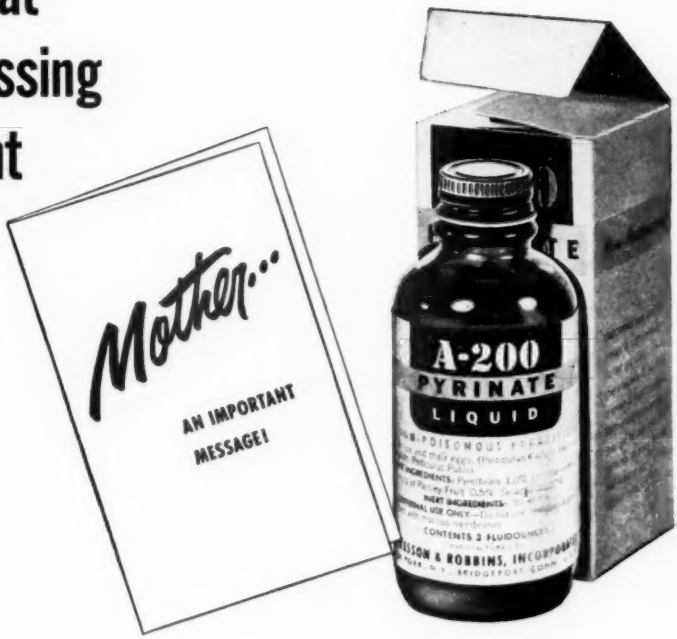
Public Health Economics

A Monthly Compilation of Events and Opinions. Published by the Bureau of Public Health Economics, School of Public Health, University of Michigan, Ann Arbor. $3 per year.

Journal of the American Medical Association

Each week the Medical Legislation Section carries summaries of federal and state bills. 535 North Dearborn Street, Chicago 10, Ill. $12 per year.

Avoid that Embarrassing Moment



IT'S AN EMBARRASSING SITUATION when the nurse must explain to parents that a child has lice. Here's a way to get around it gracefully.

Send for a supply of a little leaflet prepared by the makers of A-200 Pyrinate Liquid. It is addressed to mothers. In sympathetic and diplomatic language the mother is told about the danger of lice infestation. It also tells her:

1. A-200 is a sure, fast killer of lice, and their eggs . . . on contact. One 15-minute application is usually sufficient.

2. A-200 is non-poisonous, non-irritating, and leaves no tell-tale odor.

3. A-200 is easy to use. It is a liquid . . . no greasy salve to stain clothing. Especially recommended for children.

McKESSON & ROBBINS, INC.
BRIDGEPORT, CONN.
Famous for Quality since 1833

McKesson & Robbins, Inc., Bridgeport, Conn.

Please send me a supply of the leaflet, "Mother . . . an Important Message."

Name_____

Street_____

City_____ Zone___ State_____

The Ads Have It

Diaparene, formerly called Diapene, provides sustained non-mercurial antiseptic, deodorizing protection against irritating bacteria deposited by stool and urine. Comes in two forms (1) as an ointment for the skin and (2) as a tablet for antiseptic rinsing of the diapers to prevent urinary ammonia formation, the direct cause of urine scalds and diaper rash "ammonia dermatitis."

Write to Homemakers' Products Corporation, 380 Second Avenue, New York 10, N. Y., attention Thomas J. Mahon, for free professional samples.

• • • •

The Lane Bryant Public Relations office informs us nurses conducting mothers classes may have sets of STORK FACTS by writing to Hedda Hendrix at 465 Fifth Avenue, New York 17. STORK FACTS are prepared by the Maternity Center Association. 'Nuff said.

• • • •

EASY-SERVE, a new bed tray manufactured by Replogle Globes, Inc., 325 North Hoyne Avenue, Chicago offers new comfort to convalescents and invalids. It can be used for eating, reading, and writing in bed, and it fits perfectly between the arms of a wheelchair or armchair. It will not collapse while being used as a bed tray. Yet it makes a grand reading stand, because the top can be tilted to any position by simply the gentlest pressure. EASY-SERVE is available in two sizes. One model has a 12″ x 20″ topboard and retails for $3.95 and the 15″ x 20″ model is $4.95. This tray comes in three pastel colors—blue, pink, and ivory, and is attractively decorated with a floral design.

An interesting new development in inunction therapy

Because of the constant demand for an external preparation that can be safely used as a "home remedy," we have developed **Antiphlogistine Rub A-535.**

Rub A-535 is intended for the symptomatic relief of those conditions for which external analgesics and counter-irritants are commonly used. A-535 contains a combination of analgesics with a high percentage of methyl-salicylate in a new type of greaseless, stainless, vanishing base, which permits ease of application and almost instant utilization of the medications.

Because home remedies are used generally, we believe the manufacturer has a **dual responsibility. He must offer only** such products which may safely be used in the average household and must inform the medical profession of the products' ingredients and action.

The formula of Rub A-535 is

Methyl-Salicylate	12%
Oil of Eucalyptus	½%
Menthol	1%
Camphor	1%
Base (specially prepared)	85½%

Antiphlogistine Rub A-535 has been thoroughly tested both clinically and in over 6,000 homes.

THE DENVER CHEMICAL MANUFACTURING COMPANY, Inc.
163 Varick St., Dept. 7, New York 13, N. Y.

The above advertisement is currently appearing in the New York State Journal of Medicine and other medical publications.

POSITIONS AVAILABLE

WANTED—Public Health Nurses for overseas service. Require supervisory or organizational experience to develop maternal, infant and child care projects and organize small hospitals and dispensaries as well as develop overall public health program. Speaking knowledge Yiddish or French essential. Beginning salary $4,000 with yearly increments in addition to living cost allowance. Contact: Robert Pilpel, Secretary, Medical and Health Committee, American Joint Distribution Committee, 270 Madison Avenue, New York 16, N. Y.

WANTED—Public health nurse with certificate and year experience. Government field work; southwestern Oklahoma; good location; over $300 per month; 40 hour week; one month paid vacation; yearly paid sick leave; automatic promotion every eighteen months, retirement system, disability compensation, automobile and travel expenses furnished. Address: Box 139, Lawton, Oklahoma.

WANTED—Public Health Nurse—interesting position in Social Hygiene program. Address: New York Tuberculosis and Health Association, 386 4th Avenue, New York 16, N. Y.

WANTED—Supervising public health nurse for modern generalized nursing program. Minimum requirements, public health certificate or one year of graduate study in public health nursing. Salary range $278 to $318; 40 hour week; retirement plan; sick leave. Write: Charles A. Neafie, M.D., Director, Department of Public Health, Pontiac 15, Michigan.

WANTED—Supervisor for staff of 15 nurses; private organization; bedside care and maternity service; salary based on experience, 40 hour week; vacation with pay; sick leave; retirement plan. Requirements: thorough field experience; 1 year of postgraduate study; some knowledge of supervision. Opportunity for advancement. Write: Visiting Nurse Association, 316 Elizabeth Street, Utica 3, New York

WANTED—Education supervisor. Challenging opportunity in a combined agency financed by official and non-official funds. Generalized program; graduate affiliation with two university programs. Staff consists of 13 public health nurses; 1 clinic nurse, 1 general supervisor, 1 educational supervisor, 2 secretaries, 1 clerk. One hour from New York City. Salary open. Apply: Box DC, NOPHN, 1790 Broadway, New York 19, N. Y.

THE CHILDREN'S MEDICAL CENTER OF BOSTON, by arrangement with the National Foundation for Infantile Paralysis, is offering courses in the care of patients with poliomyelitis.

PHYSICAL THERAPY—June 27, 1949. Six week and three month courses for qualified physical therapists. Treatment of acute, convalescent and chronic phases of poliomyelitis.

COURSES FOR GRADUATE NURSES. One month and two month courses running simultaneously and beginning **June 27, 1949** and again **October 3, 1949.**

For information write to the **Director of the Physical Therapy Department, or of the School of Nursing before June 1, 1949.**

☐ *Should he?*

☐ *Shouldn't he?*

How do you vote on teething rings? A teether's mother needs your answer to this and many other questions. For instance: what should a baby with a few teeth eat? Gerber's Junior Foods, uniformly chopped, make chewing easier.

Added plus: babies like the naturally good taste of Gerber's—including the delicious

NEW GERBER MEATS! They're Armour quality Beef, Veal, Liver. Junior and Strained.

Better transition from Strained to Junior Foods

1. Gerber's Junior Fruits, Vegetables, Combinations and Desserts come in the same size container as Strained. So baby can have *more* variety with *less leftovers.*

2. Gerber's New Meats (Strained and Junior) come in one size container, too. Make change-over easier. Cost less than home-prepared meats.

FREE! Samples of Gerber's Junior Foods plus meat analyses cards. Write to Dept. PN3-9, Fremont, Mich.

Babies are our business... our only business!

Gerber's

BABY FOODS

Fremont, Mich.—Oakland, Calif.

3 CEREALS • 23 STRAINED FOODS • 18 JUNIOR FOODS

NOPHN *Seersucker Ensemble*

HERE is **BRUCK'S** famous, blue-striped, **NOPHN** official seersucker . . . a masterpiece of meticulous craftsmanship.

CAREFULLY DESIGNED in accordance with **NOPHN** requirements and **BRUCK'S** high standards, the dress is made with lapel front collar and small back collar.

FLATTERING, jaunty . . . the overseas cap comes to you in matching seersucker.

EVERY INCH of this sturdy, washable fabric is pre-tested and inspected. Then . . . and *only* then . . . is it fine enough to wear the **BRUCK'S** label.

STYLE 930
DRESS $8.95
Sizes 10 to 20, 40 to 46

STYLE 09
CAP, $1.50
Small, Medium, Large

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